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OF

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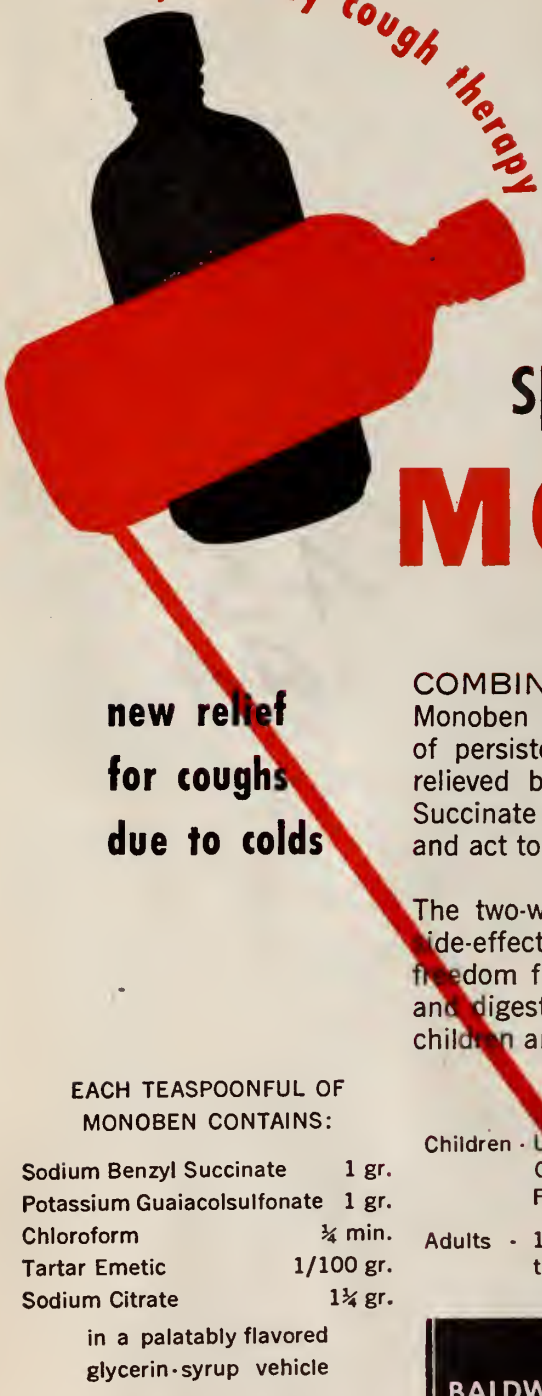
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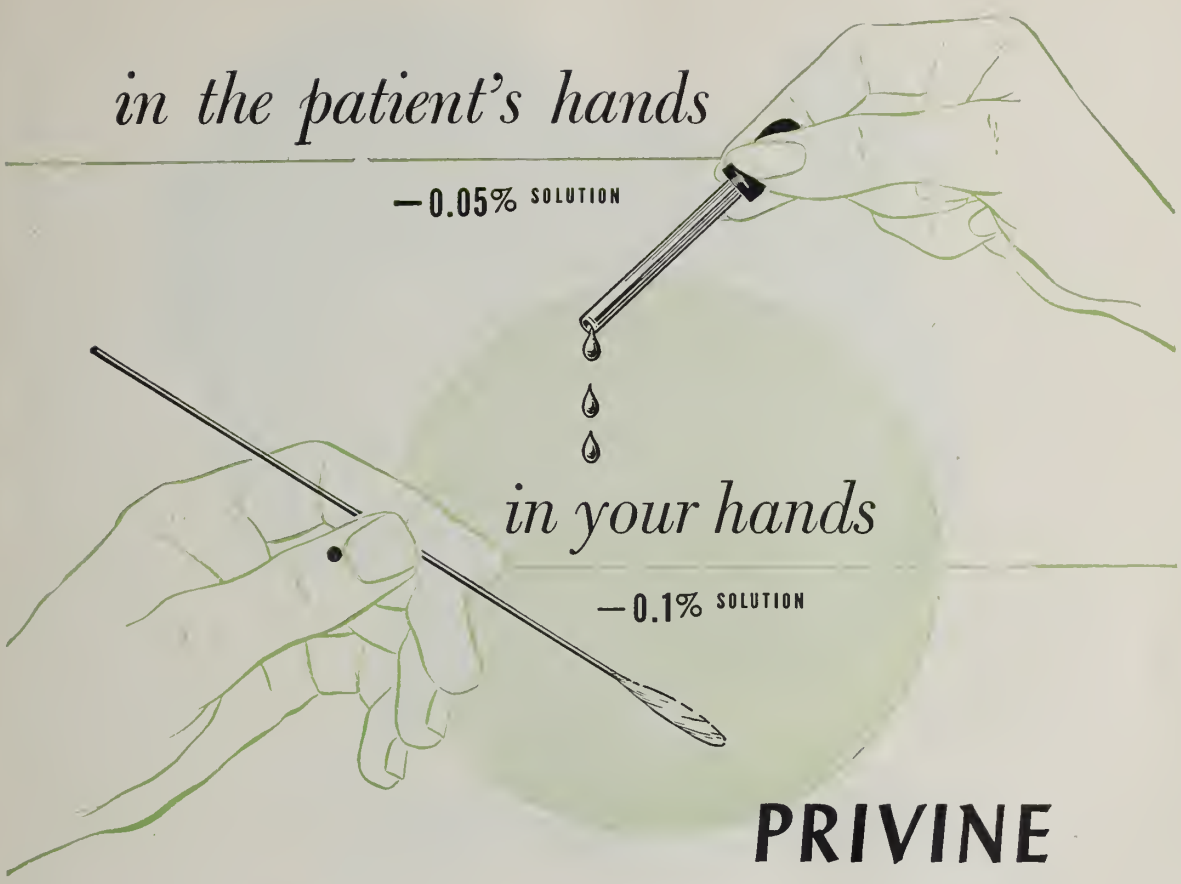
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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
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*Clements, F. W.: Rickets in Infants under One Year. The Incidence in an Australian Community and a Consideration of the Etiological Factors. Med. J. Australia, 1:336 (1942).

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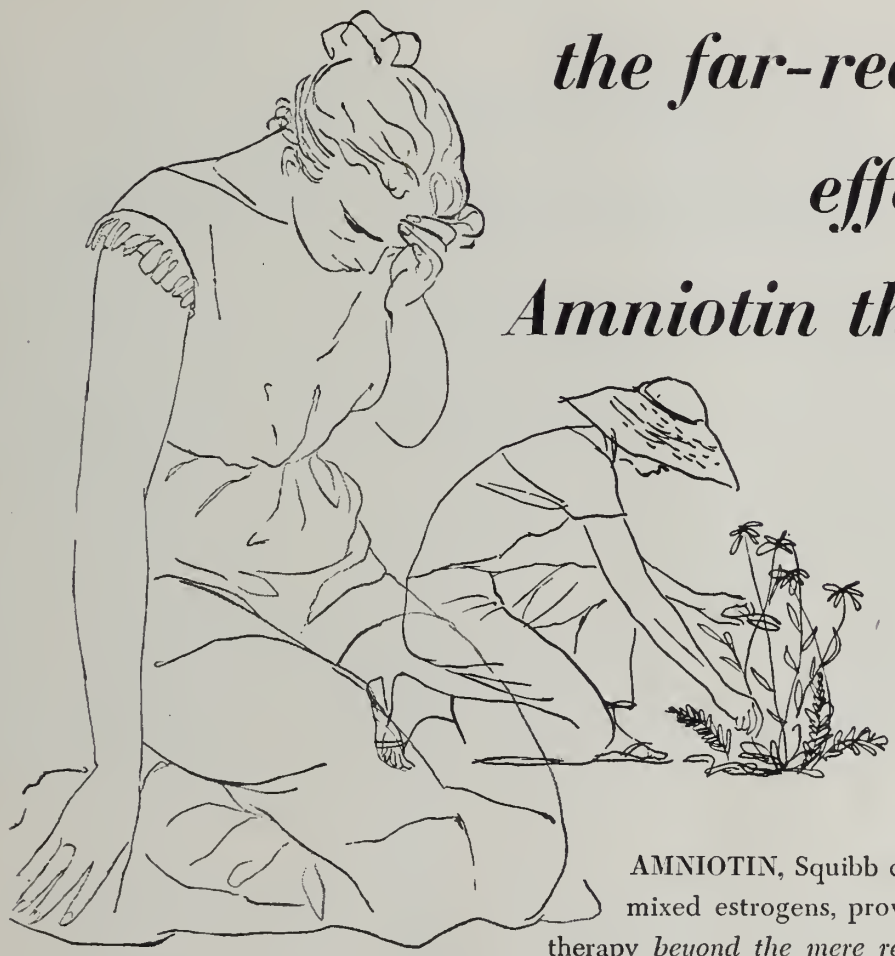
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1. Nutting, R. E.: Minn. Med., 26:1039-1044 (Dec.) 1943
2. Kugelmass, I. N.: Newer Nutrition in Pediatric Practice, p. 653, Lippincott, Phil., 1940.

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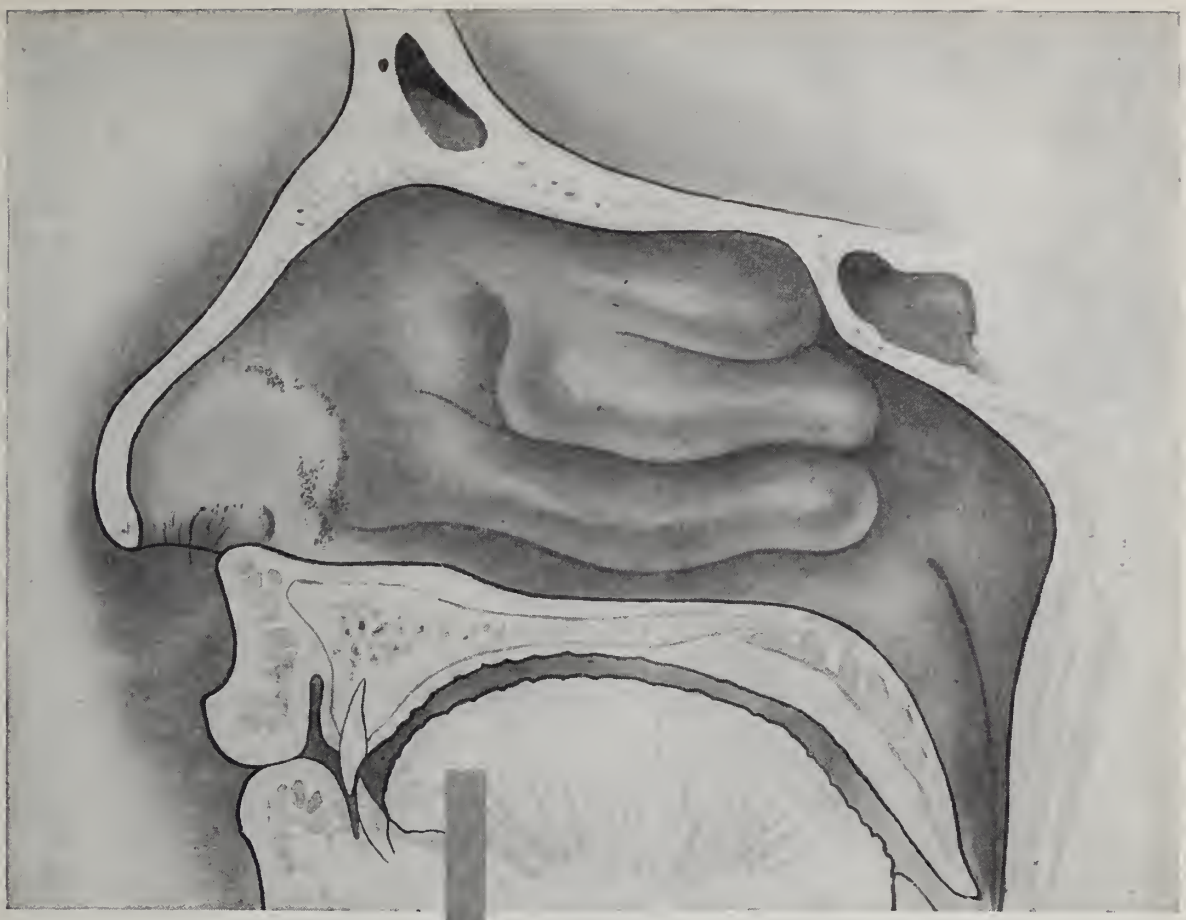
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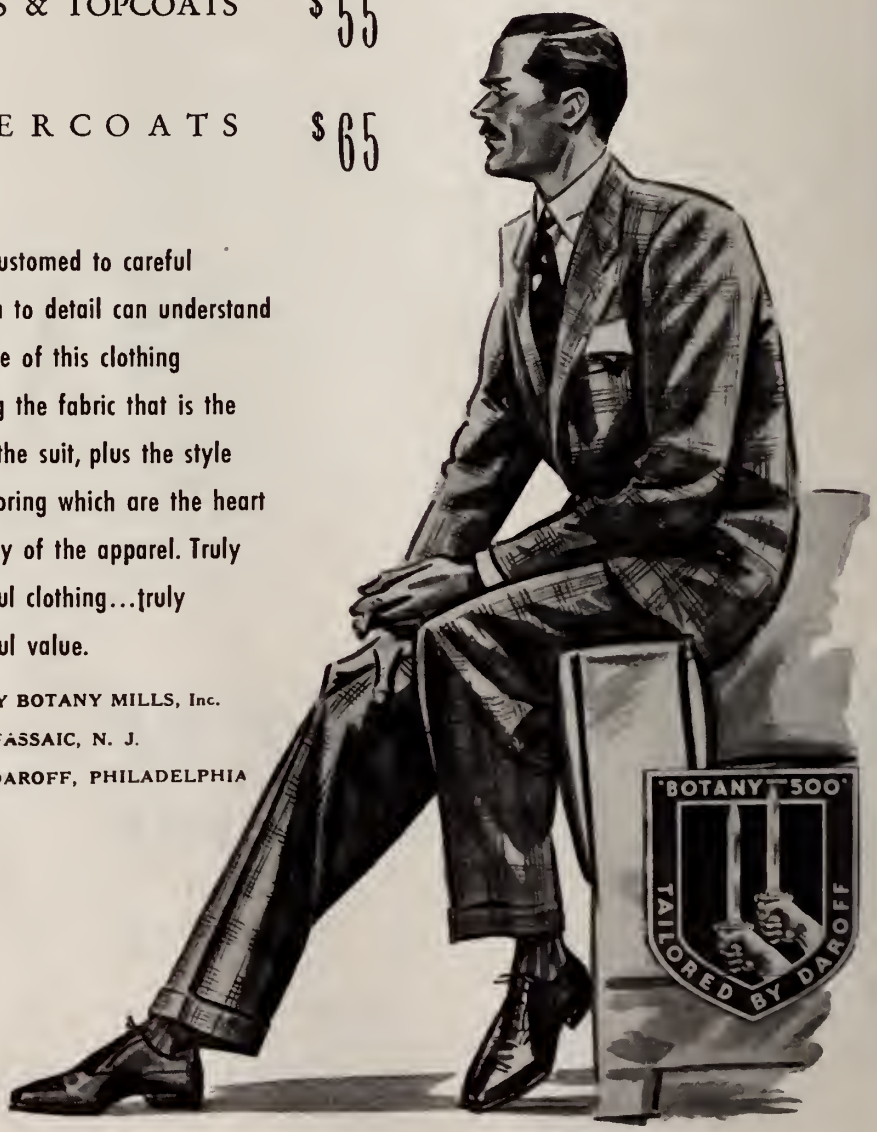
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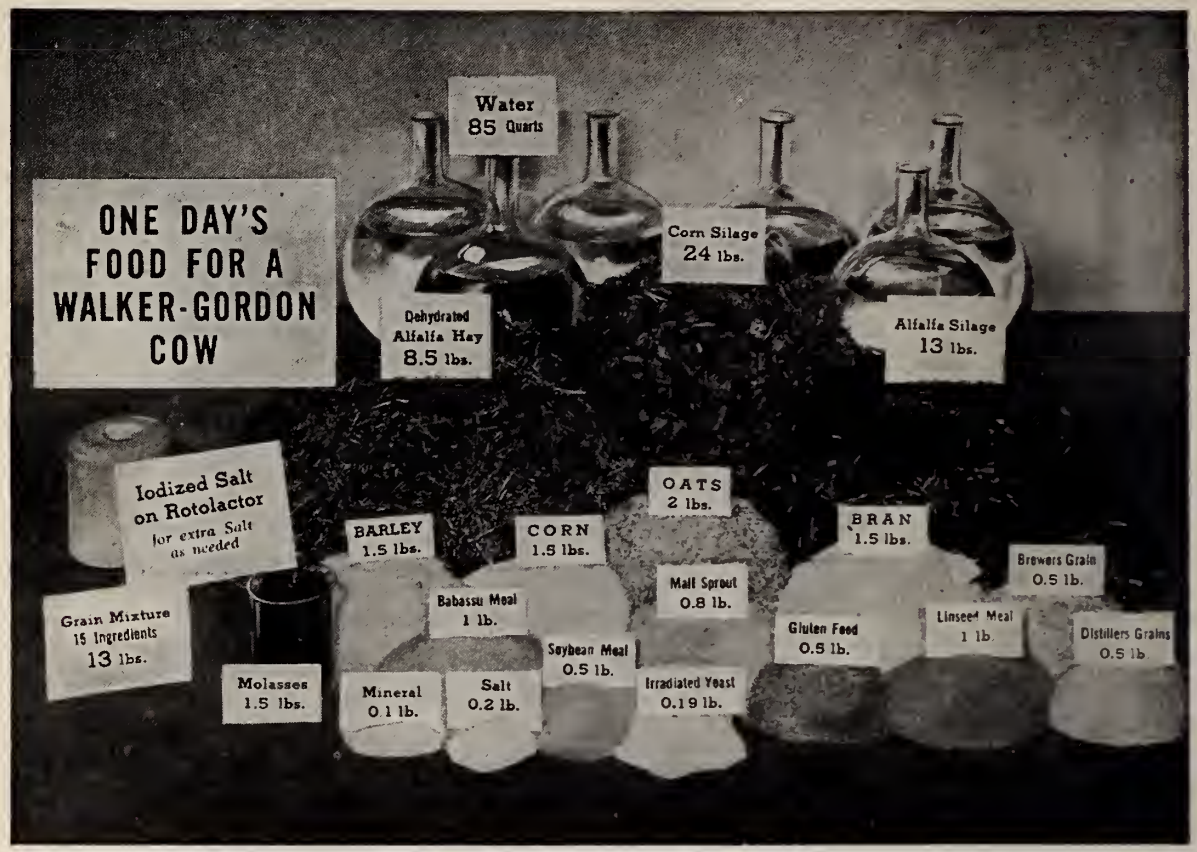
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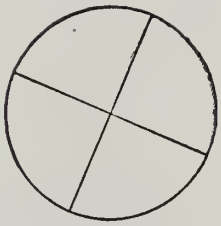
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[1]Harris, S. C.; Ivy, A. C., and Searle, L. M.: THE MECHANISM OF AMPHETAMINE-INDUCED LOSS OF WEIGHT: A Consideration of the Theory of Hunger and Appetite, J.A.M.A. 134:1468 (Aug. 23) 1947.

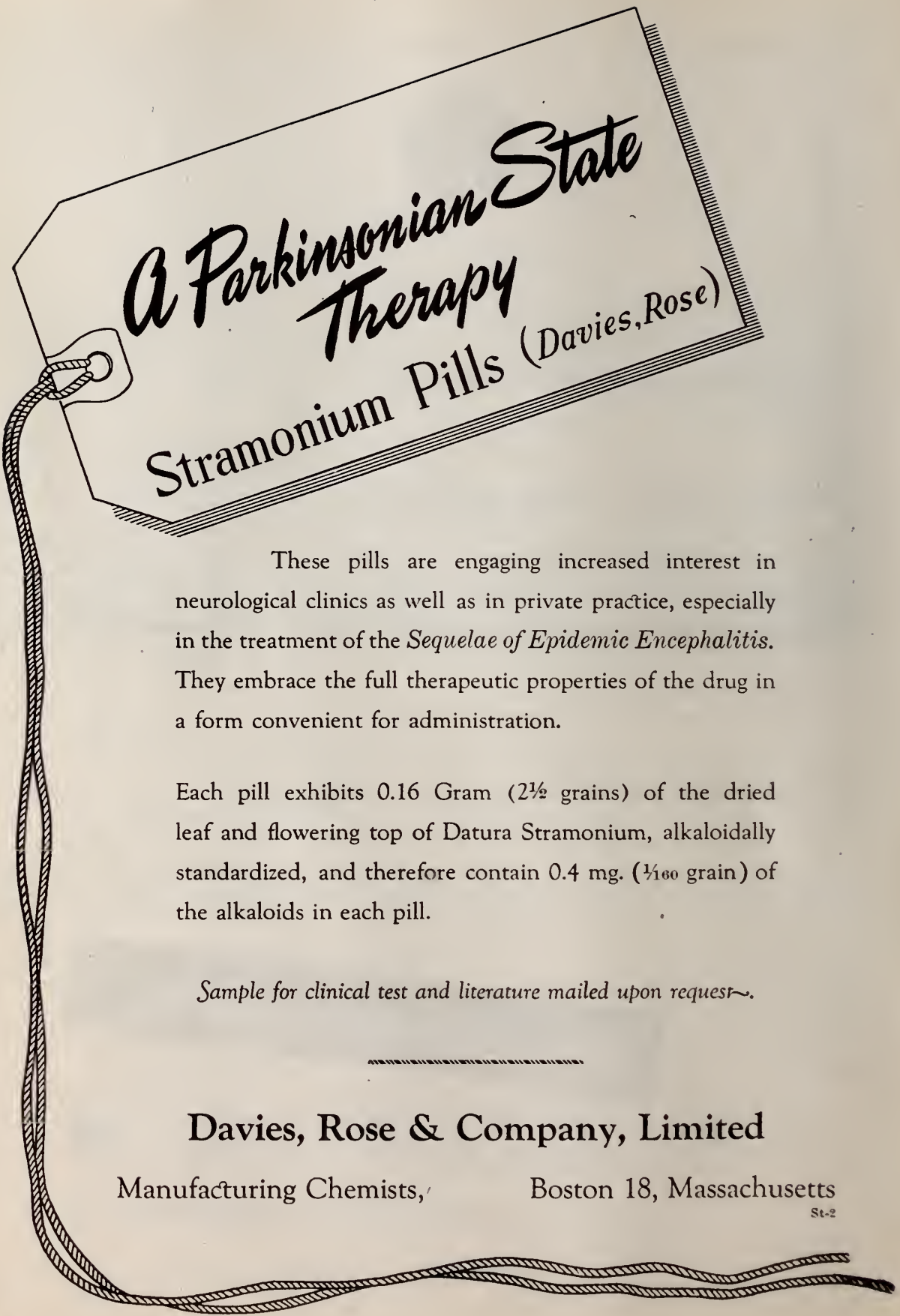
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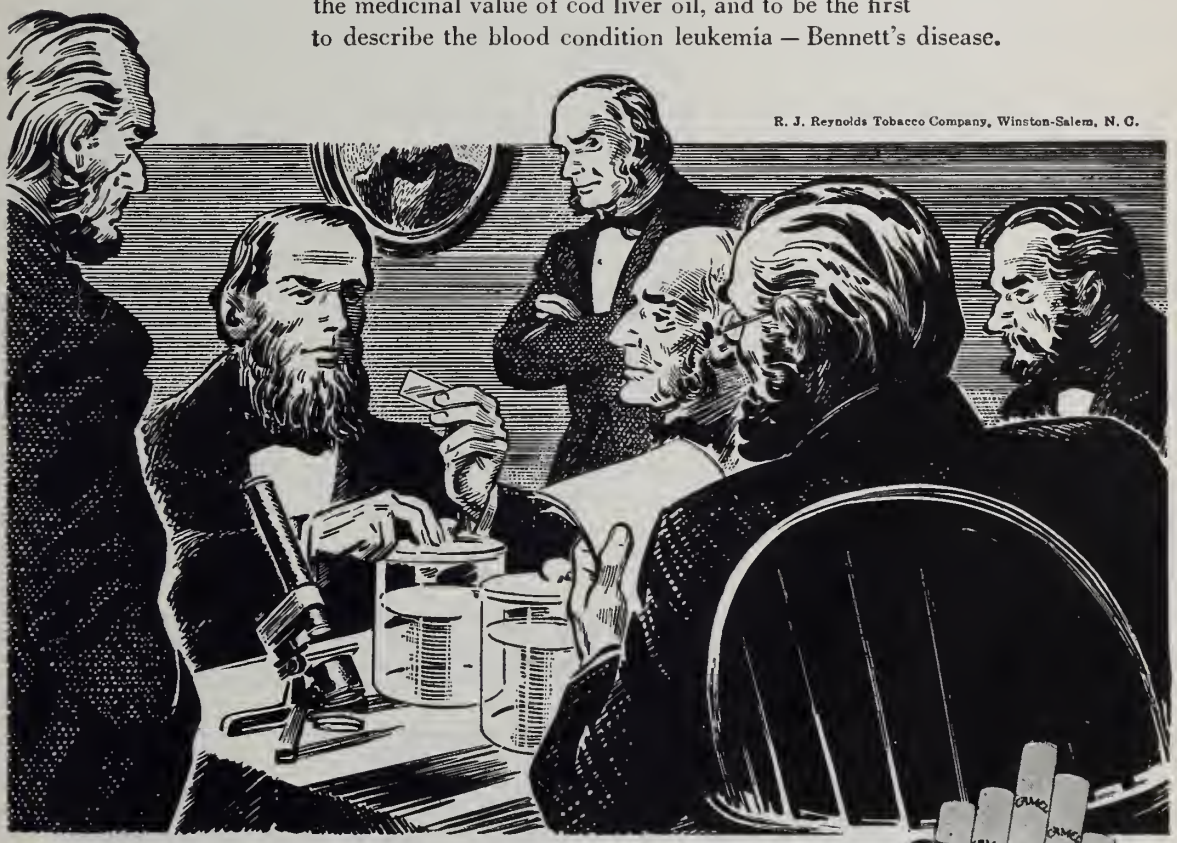
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1. Dunn, H. L.: Am. J. Pub. Health 36:1412 (Dec.) 1946.

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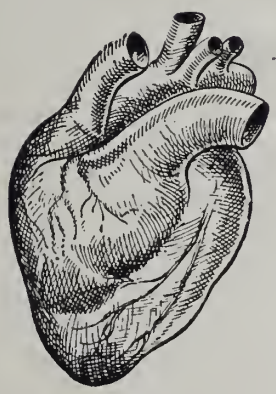
1. Youmans, J. B.: Virginia Med. Monthly, 72:238, June, 1945

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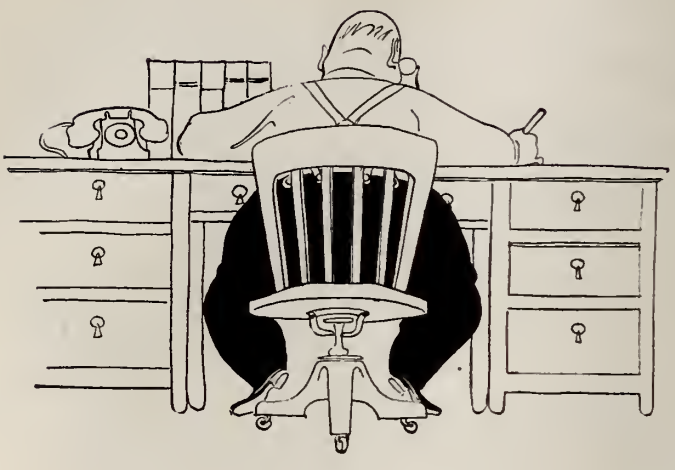
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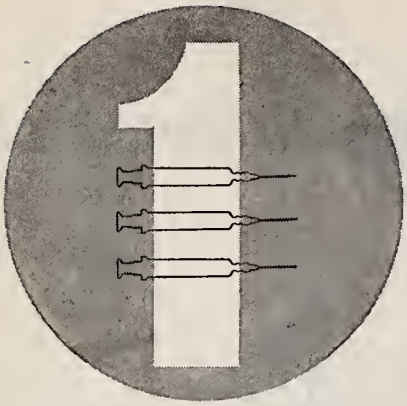
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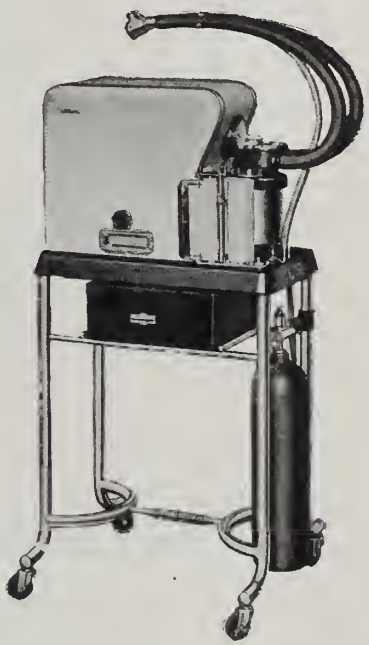
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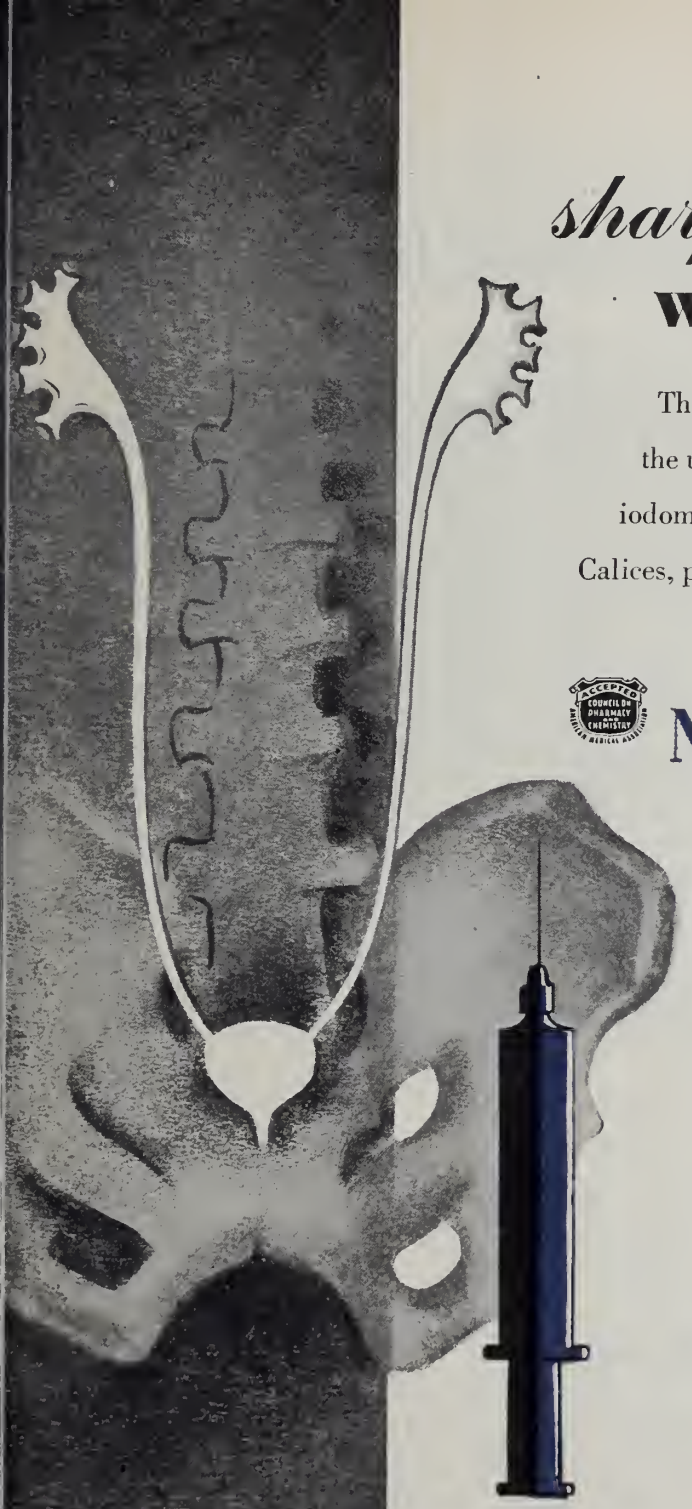
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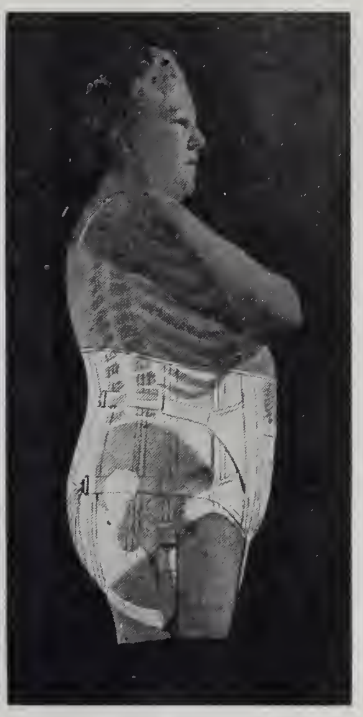
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THE PRESIDENT'S PAGE

THE VETERANS MEDICAL CARE PROGRAM

With the rapid demobilization following VJ Day in August 1945, the problem of the medical care of veterans suddenly catapulted into an issue of major importance demanding prompt and efficient organization of civilian physicians to cope with it properly. We were acutely aware of our responsibility and The Medical Society of New Jersey promptly undertook to mobilize its members to assist the government in providing medical care for those veterans who needed it. The Monmouth County Medical Society came forward at once with a carefully thought out plan for the conduct of pension examinations and the treatment of veterans suffering from service connected disabilities. This project was so practical and comparatively simple that it received the attention and approval of General Hawley, Chief Medical Director of the Veterans Administration, who advocated the adoption of similar plans throughout the United States. General Hawley acknowledged this as a pioneer plan and applauded the Monmouth County Society for its foresight and efficiency. Your Board of Trustees and The Medical Service Administration of New Jersey devoted an enormous amount of time and thought to develop an efficient method of conducting pension examinations on a large scale and to provide actual treatment of veterans with service connected disabilities on the home care plan basis. We succeeded in preserving the principle of free choice of physician on a fee for service basis and we evolved a schedule of benefits which, on the whole was eminently fair to the participating physicians and was satisfactory to the Veterans Administration.

On March 15, 1946, The Medical Service Administration of New Jersey undertook to process all pension examina-

tions and to handle the authorizations for home medical care, but after a trial period of five weeks, it became apparent that by this method we were merely duplicating paper work which properly should have been done by the clerical force of the Veterans Administration. Instead of expediting the work we became a bottleneck which actually retarded it. This arrangement was terminated on May 15, 1946, and we began at once the negotiation of a new contract with the Veterans Administration. After considerable discussion, we reached a new agreement which included provision for a Liaison Officer between The Medical Society of New Jersey and the Veterans Administration whose expenses including salary, were to be assumed by the Government. Dr. Edward T. Yorke accepted this assignment and served competently in this capacity until December 31, 1947.

In August 1946, it appeared that more than 100,000 pension examinations were going to be required during the next eighteen months. At the request of the Regional Office in Newark, The Medical Society of New Jersey undertook to establish fifteen examining units at strategic points throughout the state in order to carry this load. Special corporate groups were set up in each county in which units were to function in order to deal with the financial aspects of the project. After months of effort a number of these corporate bodies signed contracts with the government and a small number of pension examinations were made in a few counties by organized groups of examiners in which all required specialists were represented.

By February 1947 it became obvious that the existing facilities of the Veterans Administration itself were adequate to meet all demands for pension examinations. The activities of our examining units were accordingly discontinued.

Beginning July 1, 1947, negotiations with the Veterans Administration were conducted from time to time until, on November 22, 1947, The Medical Society of New Jersey signed a new agreement under which we dispensed with the services of a Liaison Officer after December 31, 1947. For a trial period of six months we shall operate without a Liaison Officer. Difficulties, if any, between physicians, and the Veterans Administration will be handled by the Central Veterans Liaison Committee under the Chairmanship of Dr. Joseph F. Londrigan.

The medical care of the veteran has now been organized on a fairly efficient and satisfactory basis and it is not likely that we, as a Society, will be called upon by the Veterans Administration to do much more than provide a list of fee designate physicians to render authorized medical care to veterans with service connected disabilities. At present it appears likely that the Veterans Administration will soon have adequate facilities and personnel with which to assume full responsibility for the entire Veterans Medical Care Program.

I wish to pay tribute to the invaluable service which Dr. Edward T. Yorke rendered to The Medical Society of New Jersey as Liaison Officer with the Veterans Administration. His duties were difficult and trying but he discharged them conscientiously and efficiently and we owe him a debt of gratitude for a very real contribution to our effort to serve our government in a time of need.

I wish also to remind you of the monumental contribution to the general welfare which was made by General Paul R. Hawley by bringing about such great improvement in the standards of medical care of veterans. Few men in public life have ever demonstrated greater honesty, sincerity, fairmindedness and competence, both professionally and administratively than has General Hawley during his tenure of office as Chief Medical Director of the Veterans Administration. He has been impartially mindful of the

welfare of both veteran and physician, and has done much to preserve the status of private practice as we have known it and as we wish it to continue. The entire medical profession of the United States owes General Hawley its plaudits. By his departure from the Veterans Administration we have lost a staunch advocate and a valiant defender. We wish him every success in his new endeavors.

ROYAL A. SCHAAF, M.D.,
President.

FRANK G. SCAMMELL, M.D., 1877-1947

The short and honorable list of Fellows of The Medical Society of New Jersey was reduced once more when Dr. Frank G. Scammell died on December 6, 1947. He was, until last spring, President of this society. Dr. Scammell was born in Trenton in 1877, and after a brief trial of pharmacy, elected to become a physician. Graduating from Philadelphia's Medico-Chirurgical College at the early age of 22, he practiced in Trenton for five years, and then decided he wanted post-graduate training. This was an unusual decision in those days, for at the turn of the century most practitioners were satisfied to advance their knowledge by experience, reading, and attendance at meetings. Post-graduate courses were few, and only the most scholarly of physicians then felt an urge to seek more formal training. Dr. Scammell did it however, going to Philadelphia for advanced studies in gastro-enterology. He then practiced for two decades in his native city, and developing an increasing interest in surgery, went to Europe in 1927 for further training in operative surgery.

Dr. Scammell always felt a special concern for public health. He was a pioneer in vaccination and served both as city physician and county physician. He was surgeon to the Mercer Hospital, the Orthopedic Hospital, and the State Hospital, all in Trenton. His organizational talents won early recognition. He was active in the Mercer County Medical Society, the Society of Surgeons of New Jersey, the medical staff of Mercer Hospital and The Medical Society of New Jersey. And he was president of all four of these organizations.

Most of us saw him last at the 1947 Annual Meeting, when he turned over the gavel to the present President. It was the kind of occasion which, in less skilled hands, becomes solemn or stuffy or dismally serious. All of us remember however, how Dr. Scammell closed his administration with a polished whimsical and witty address. He was seriously sick then, and he knew it, but he carried off the occasion with a graciousness which we now recognize as courage and gallantry.

THE SOCIETY'S YEAR—1947

At the end of 1946, Dr. Stanley Nichols warned us that 1947 was going to be a "year of decision." The year is over, and now is the time to see what decisions were made and how they were carried out. We had been talking for a long time about getting an Executive Officer. And 1947 was the year in which that decision was actually implemented. We had been realizing with increasing force that medical societies had to cultivate public relations with a surer touch. And public relations have been made the number one job of the new Executive Officer. We had long wanted to resume our fall clinical conferences. We finally made the decision: we would resume in 1947. It was done, and the Passaic County Medi-

cal Society thus played host to one of the clinical high spots of 1947. It was a year, too, in which visible advances were made in the state cancer control program, the school health program, and the graduate educational program. In 1947 the fifth edition of that valuable compendium, the *New Jersey Formulary* was released, surveys were initiated in the area of cardiac facilities, the nursing practice act was revised, the state health department was completely re-organized, and seven new scientific sections were added to the Society's scientific assembly.

Three new state specialty medical societies were organized during 1947, as was a physician's post of a veterans' organization. The Woman's Auxiliary embarked on a pioneer project, a health education round table. For the first time in our history, the Governor of New Jersey spoke at our annual meeting. The *New Jersey Doctor's Almanac,* a unique source book of medical data, was prepared and released by our Publication Committee. Our Society's report on "Implementing the National Health Program in New Jersey" won the accolade of the American Medical Association, which asked for and obtained, several thousand copies for nationwide distribution. It was a satisfying year, though it had its melancholy spots too. The Society lost such prominent members as William J. Carrington, Frank G. Scammell, C. C. Beling, James S. Plant, Seth Sprague, Samuel Barbash, Henry Diverty and Thomas McG. Brennock. Apart from these losses, it was a lively, and progressive year, and carried within it dynamic seeds which will come to fruition during 1948.

STARVING CHILDREN

In the total world holocaust, the only really innocent ones are the children. The spectre of starvation which now grimly stalks the old world will have double poignancy because of its effect on children. No doctor needs be reminded of what inadequate diet, avitaminosis and malnutrition do to growing boys and girls. The appeal for food and funds coming out of Europe and Asia has met, in some cases, with the response: "They got themselves into this mess. It's not our trouble". Though the snowballing success of *Friendship Train* has indicated that this is not a typical American reaction, there are still those who cry that they are not their brothers' keepers. Perhaps not. But the children did *not* get themselves into the "mess". And someone now must give them their daily bread.

European relief today seems to have political overtones which have kept many an American from participating. But children have no politics—though starving children after they grow up may develop some very strange politics indeed. And so the American Overseas Aid-United Nations Appeal for children has been organized to bring medical, educational and nutritional aid to the hungry and neglected children of the continent that was once the motherland of all of us. For most of us, the cry of a starving baby cannot be ignored. If there are any among us calloused to the needs of a hungry child, let it be pointed out that the underfed children of Europe in the 1920s became the soldiers of the 1940s. Purely selfish motives alone would make every American seek assurance that the next generation's leadership will not come from those warped in body or mind. And the only insurance policy against that now is to feed and care for the underfed innocents of Europe and Asia. Whatever the motive—compassion, fear of the future, or that identification which says that but for the grace of God those hungry cries might be coming from your children or mine—whatever the motive, the means are the same—a donation to the Appeal for Children, 39 Broadway, New York City 6.

ORIGINAL ARTICLES

OCCUPATIONAL BERYLLIUM POISONING IN NEW JERSEY

(With Special Reference to Its Incidence, Diagnosis and Compensation)

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HARRISON S. MARTLAND, JR., M.D.*

It is the purpose of this paper to alert the physicians of this state to the toxic effects of beryllium compounds in industry. All three of the authors attended the recent Saranac Symposium on the Beryllium Problem,[1] and two are members of a special committee of the State Labor Department in an investigation of industrial beryllium poisoning in this state.

In addition, we wish to comment upon the compensation laws of New Jersey in regard to occupational diseases and their proper coverage.

BERYLLIUM DEATHS

As far as we have been able to ascertain there have been no recorded deaths in New Jersey from industrial beryllium poisoning with the exception of the four herein reported. These four came to the attention of the Chief Medical Examiner of Essex County, whose duties (in addition to the investigation of violent and suspicious deaths) include the probe of deaths due to industrial diseases and poisonings.

All four cases were discussed at the Saranac Symposium.

CASE REPORTS

Case 1. Chronic Beryllium vs. Nickel Poisoning in 1936. This case was referred to the Medical Examiner for autopsy by Dr. Raphael Pomeranz of Newark, whose summary of the case is quoted.

Male, white, age 23. Industrial helper and chemist, exposed to mercury, antimony and lead; boiled nickel in carbon tetrachloride.

He began to complain of loss of appetite and weight with substernal pain. This was followed by shortness of breath, a non-productive cough and later by cyanosis and clubbing of fingers.

X-rays showed fine, diffuse, millet-seed nodulations over both lungs without calcification or cavitation. All tests for tuberculosis negative.

Patient was seen by several outstanding physicians with the following diagnoses:—Disseminated type of lymphoblastoma; Hodgkins' disease; miliary carcinomatosis; bronchiolitis obliterans; and possible occupational obscure dust infection. Pulmonary sarcoid was not mentioned as most clinicians were not sufficiently alerted to the sarcoids at this time.

Extensive irradiation of chest was the only treatment that gave any relief from dyspnea and cough. Course progressively down-hill and afebrile most of the time.

Autopsy showed extensive, fine, diffuse nodulations, 1 to 2 mm. in size, throughout both lungs; hilar nodes only moderately enlarged; many emphysematous areas in lungs; hypertrophy of right ventricle (1 cm. thick); chronic passive congestion of liver, spleen and kidneys; clubbed fingers and toes.

Microscopic examination showed small tubercle-like lesions with signet giant cells and without caseation and larger hyaline nodules scattered throughout lungs. Small number of similar granulomas in liver.

Toxicologic examination of lungs by chemical methods showed traces of nickel and a silica content of 2 per cent.

Comment:—The estate was awarded compensation as a death due to silicotuberculosis. With considerable sagacity Dr. Pomeranz reported this case in the literature as "Chronic Nickel Poisoning and Productive Miliary Tuberculosis",[2] basing his diagnosis on the x-rays

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1. Sixth Saranac Symposium, Sept. 29 to Oct. 3, 1947.

2. Pomeranz, Raphael: *The American Review of Tuberculosis*, 38:252 (August, 1938).

of the lungs which did not resemble any other known disease; on the microscopic picture of a productive, non-caseating tuberculosis; and the findings of nickel in the toxicologic examination.

In 1944, eight years later, deaths were occurring among workers in a fluorescent lamp factory in Massachusetts exposed to a phosphor containing zinc-beryllium-silicate. The late Dr. L. U. Gardner of Saranac found a chronic pulmonary granulomatosis closely resembling a sarcoid as the cause of death in these cases and they were spoken of as the "Salem Sarcoids". When we were informed of these cases we reviewed the slides in our case, sending them to Dr. Gardner for his opinion. They were identical with the Salem cases and a final diagnosis of chronic beryllium poisoning was made, after ascertaining that there had been an exposure to beryllium compounds while in experimental cathode tube work.

This case is of considerable importance. While at the time of death it was not recognized as a beryllium case, since neither clinician, roentgenologist nor pathologist had been alerted to this new industrial poisoning, it demonstrates that beryllium poisoning existed in New Jersey as early as 1934.

Case 2.—Chronic Beryllium Poisoning vs. Silicotuberculosis in 1944. This case was referred to the Medical Examiner for autopsy by Dr. Paul Slavin of Newark to whom we are indebted for the following information:

Female, white, age 27. Chief complaint: dyspnea. She was treated by another physician for one year for heart disease. Dr. Slavin then examined her and x-rays showed fine nodulations throughout both lungs and a cor pulmonale. There was marked cyanosis and clubbing of fingers. All tests for tuberculosis were negative. She was seen by several specialists with the following diagnoses:—Miliary carcinomatosis; Hodgkins' disease; millary tuberculosis; silicosis and Boeck's sarcoid. Dr. Slavin was of the opinion that she had some peculiar occupational lung disease but could get no definite history of exposure. It was learned after death that she had worked in the lamp industry. Dyspnea became so extreme that during the last year of life she was constantly under an oxygen mask. She died from congestive heart failure 3 years after onset of symptoms.

Autopsy showed extensive, bilateral nodulations in lungs which resembled a fine silicosis or a sarcoid. The right ventricle was markedly hypertrophied (9 mm. thick), and there was chronic passive congestion of the liver, spleen and kidneys with clubbed fingers.

Microscopic examination showed the same lung lesions as seen in Case 1. There were no granulomas in the liver.

Comment:—Specimens of the lungs were sent to Dr. Gardner who wrote us, as follows: "Its appearance is practically identical with that of the histology in the first of the so-called "Salem sarcoids" which came to autopsy. Both show the same small cellular *tubercular* lesions with giant cells containing inclusion bodies and the larger hyaline nodules. As you (HSM) apparently did, I would once have diagnosed it as silicosis on the basis of the latter and probably assumed the presence of a non-caseating tuberculosis as the cause of the other lesions."

This case again illustrates the difficulty in recognition of chronic beryllium poisoning unless you have been alerted to the disease, since such an outstanding authority as Dr. Gardner would have not diagnosed the condition except for the fact that he was at the time studying the Salem cases.

Case 3.—Acute Beryllium Poisoning in 1947. This was reported to the Medical Examiner for investigation as a chemical pneumonitis or virus pneumonia.

Male, white, age 22. No previous occupational hazard. X-rays of chest at beginning of work showed no disease. Worked in phosphor department of lamp company for 31 days, on night shift, as a mill operator loading and unloading fired and unfired *phosphor powder.* Respirators were supposed to be used. On the last day of work he complained of pains across chest and was laid off. Two days later he was admitted to hospital with marked dyspnea, cyanosis, chest pains and weakness.

While in hospital he ran the course of a bilateral lobular pneumonia with little fever, no leucocytosis and no pathogens in sputa.

X-rays showed extensive, bilateral lobular pneumonia. He died 22 days after onset, modern pneumonia therapy not influencing the course of his disease.

Autopsy showed extensive bilateral lobular pneumonia, the lungs almost solid and dripping blood; cut sections usually sank; cut surface grayish-red to dark-red, with organization, marked edema and hemorrhagic extravasations. Left lung 1600 Gm.; right lung 1800 Gm.

Microscopic examination showed lobular pneumonitis with exudate of plasma cells, lymphocytes and large mononuclear cells in alveoli and interalveolar septa with striking absence of polymor-

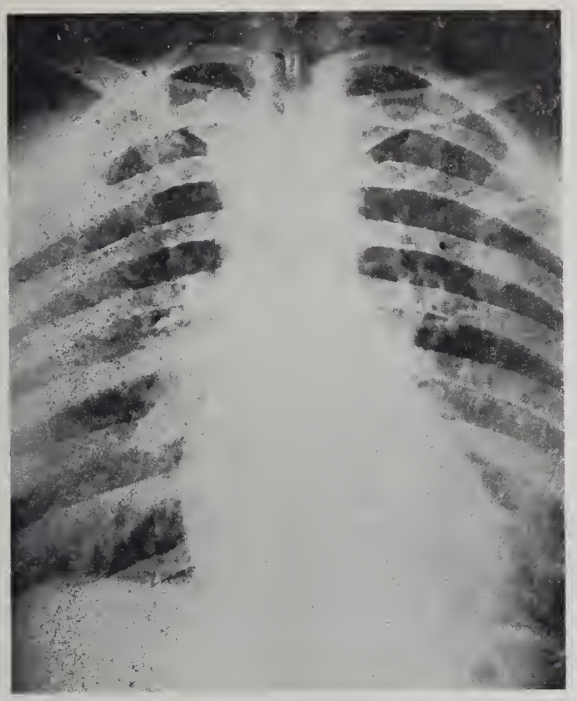


Fig. 1—*Acute Beryllium Poisoning*—Case 3. Extensive, bilateral, diffuse, lobular pneumonitis.

phonuclear leucocytes. There was extensive fibroblastic organization of intra-alveolar and inter-alveolar exudate; squamous cell metaplasia of epithelium of alveoli and terminal bronchioles and large areas of hemorrhagic infiltration.

Toxicologic examinations made by our toxicologist and the Kettering Laboratory at Cincinnati showed small amounts of beryllium in the lungs and liver. Silica content of lungs normal. The Kettering analysis disclosed the following:

Beryllium in 100 Gm. of wet liver . . . 20 micrograms (or 0.68 milligrams in lungs)

Beryllium in 100 Gm. of wet liver . . . 4 micrograms (or 0.04 milligrams in liver)

The Kettering analysis was made by their newly developed technic of spectrographic examination.

Comment:—The clinical course, x-ray and autopsy findings of this case are similar to the cases of beryllium pneumonitis described by Van Ordstrand et al,[3] in 1945. The microscopic appearance of the lungs is identical with Goldblatt's description in the Van Ordstrand[3] report.

While the amounts of beryllium found in the lungs are very small and might represent only exposure, there has been such meager toxicologic data on these cases that any positive opinion, as to the lethal dose that must be recovered

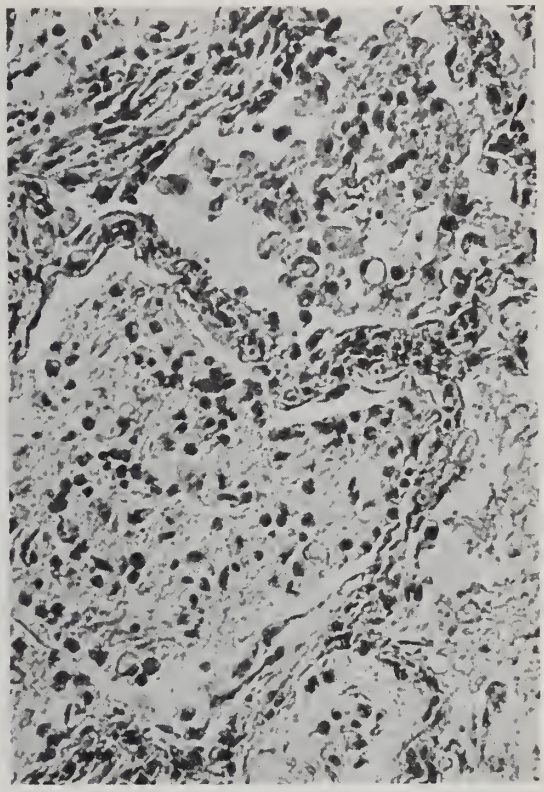


Fig. 2—*Acute Beryllium Poisoning*—Case 3. Organizing lobular pneumonia. Note absence of polymorphonuclear leucocytes. X 250.

in either the acute or chronic forms of beryllium poisoning, cannot be evaluated with accuracy at present.

Therefore, there might be some authorities who will question the diagnosis of beryllium poisoning in this case and attribute death to an organizing virus pneumonia which it closely resembles. However, the occurrence of 38 cases of chemical penumonitis with 5 fatalities in the Cleveland plants in beryllium copper production and the low mortality in virus pneumonias would be against such an explanation. See figures 1 and 2.

Case 4.—Chronic Beryllium Poisoning in 1947. This was reported to the Medical Examiner as an occupational death in which civil suit had already been brought for uranium poisoning while working in atomic research.

Female, white, age 31. No previous occupational hazard. In 1942 started to work in lamp

3. Van Ordstrand, H. S.; Hughes, Robert; De Nardi, J. M., and Carmody, Morris G.: *Journal of the American Medical Association*, 129:1084 (Dec. 15, 1945).

industry and for 3 months was *oscillating uranium in beryllium crucibles* in a vacuum with high frequency coils. On opening apparatus after cooling noticed black smudge over face and in nostrils with choking sensation and cough.

After this until 1946 was drawing beryllium wire and sheet metal, exhausting tubes, braising and soldering. Towards the end of 1944, she developed a non-productive cough and was short of breath. By the end of 1946 she was so weak and so short of breath that she had to give up work.

From this time on she became progressively worse with marked dyspnea, loss of weight and insomnia. Lips cyanotic, fingernails cyanotic and clubbed.

X-rays showed fine nodulations throughout both lungs giving a reticulated and "snow storm" appearance. The hilar nodes were not unduly enlarged. Pulmonary artery prominent.

Electrocardiograms showed right axis deviation. She was tested for radioactivity with a sensitive Geiger counter and no abnormal radioactivity was present.

A diagnosis of *delayed chemical pneumonitis* was made by Dr. I. L. Applebaum of Newark. No beryllium was found during life in urine, blood or feces, but more accurate technic was not available at the time.

Towards the end the dyspnea was relieved only by constant oxygen. Cardiac failure of the congestive type set in with large liver, ankle edema and slight ascites. She died *5 years after exposure* to beryllium compounds and *3 years after onset* of symptoms.

Autopsy showed a chronic, diffuse, bilateral, interstitial pneumonitis with innumerable small, discrete and confluent, non-caseating, non-calcifying nodulations, 1-2-5 mm in size. There was marked compensatory emphysema over most of the lung and all cut sections floated. Right lung 720 Gm, left lung 620 Gm. A cor pulmonale was manifested by hypertrophy of right ventricle (7 mm thick) and there was chronic passive congestion of liver, spleen and kidneys.

Microscopic examination showed discrete and confluent nodulations throughout the lungs, usually with centers of epithelioid cells without caseation or calcification. These were surrounded by lymphocytes, plasma cells, monocytes and many foreign body giant cells. Practically no polymorphonuclear leucocytes, no eosinophils. The hilar nodes showed the same granulomatous lesions with larger hyaline nodules resembling somewhat silicotic nodules. The whole picture was identical with that seen in Boeck's sarcoid. Many of the giant cells contained large inclusion bodies, often ring-like, some almost protozoal-like, staining a deep purple with hematoxylin. Similar extra cellular bodies were seen in the graulomatous lesions. The liver showed marked periportal fibrosis due to chronic passive congestion with atrophy of liver cells about central veins, there were no granulomas. Cultures and guinea-pig innoculations from the lungs were negative for tubercule bacilli and other pathogens.

Toxicologic examination made by the Kettering Laboratory using their newly developed spectrographic analysis was, as follows:

Lungs	12	micrograms beryllium per 100 Gm of wet tissue
Liver	8.4	" " " " " " " "
Spleen	4.3	" " " " " " " "
Bones	13.5	" " " " " " " "
Kidneys	27.2	" " " " " " " "

Taking into consideration the weights of the organs, a rough estimate of the total beryllium content of these organs would be, as follows:

Lungs	0.162	milligrams
Liver	0.134	"
Spleen	0.0086	"
Bones	2.7	"
Kidneys	0.1	"

Comment:—This case is similar in its symptomatology, course, autopsy and microscopic findings to the so-called "Salem cases" of chronic pulmonary granulomatoses as reported by Hardy and Tabershaw[4] in 1946, as "Delayed Chemical Pneumonitis occurring in Workers exposed to Beryllium Compounds".

In addition it affords about the best example so far of a complete toxicologic examination in any of the beryllium cases.

The large amounts found in the skeleton suggest that, although the lung lesions caused death, there is a distribution of beryllium over most of the body. The disease is, therefore, systemic in nature (inhalation and ingestion of fumes and dust, the latter often of colloidal size) and the metal is deposited in the reticuloendothelial system in a manner similar to lead, radium, arsenic, etc.

The large amounts in the kidneys, five years after exposure, hint that there is a possibility of finding a test in the urine during life which will show beryllium in sufficient quantities to make a diagnosis. In fact the Kettering Laboratory has recently developed such a method. See Figures 3, 4, 5, 6 and 7.

4. Hardy, Harriet L., and Tabershaw, Irving R.: *Journal of Industrial Hygiene and Toxicology*, 28:197 (September 1946).



Fig. 3—*Chronic Beryllium Poisoning*—Case 4.

Diffuse pulmonary granulomatosis. Note reticulated appearance and "snow-storm" effect. No calcification or cavitation. Also note prominent pulmonary artery indicating "Cor Pulmonale".



Fig. 4—*Chronic Beryllium Poisoning*—Case 4.

Enlarged portion of roentgenogram to show reticulated and "snow-storm" effect.

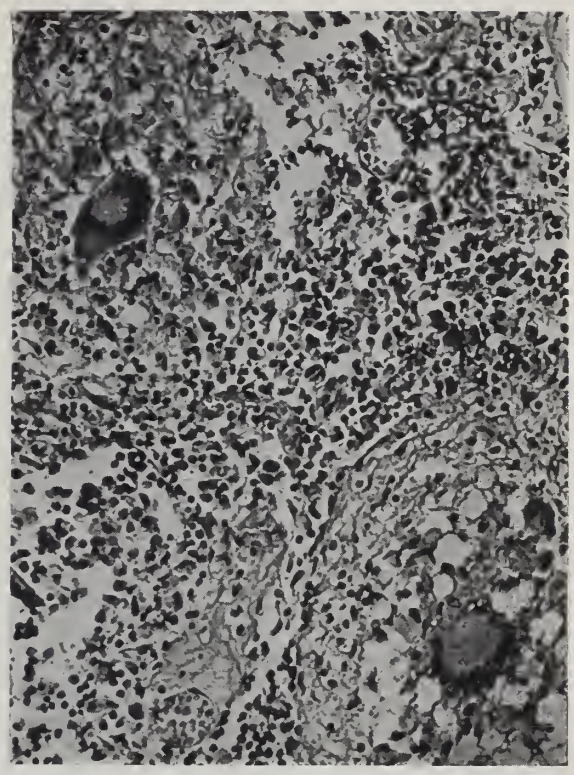


Fig. 5—*Chronic Beryllium Poisoning*—Case 4.

Beryllium granuloma. Note epithelioid tubercule with lymphocytes, mononuclears and giant cells. This lesion is practically indistinguishable from Boeck's sarcoid. X 250.

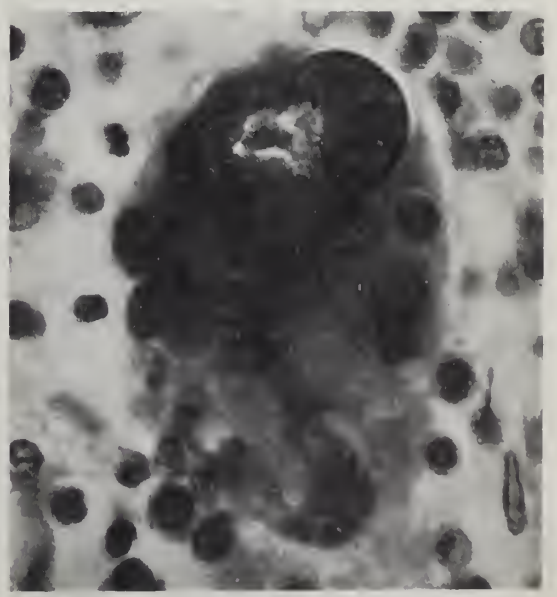


Fig. 6—*Chronic Beryllium Poisoning*—Case 4.

Giant cell containing inclusion body. Found in pulmonary granuloma. X 1600.

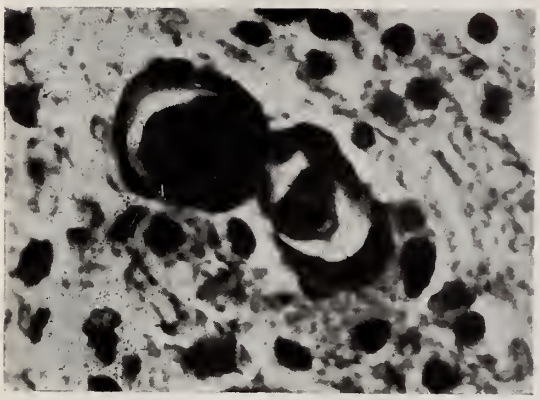


Fig. 7—*Chronic Beryllium Poisoning*—Case 4.

Extracellular, ring-like inclusion bodies. Found in pulmonary granuloma. X 1600.

SUMMARY OF OUR PRESENT KNOWLEDGE

Based on a study of the above reported cases; the Van Ordstrand report [3] describing the exposure, symptomatology and pathology of acute beryllium poisoning; the Hardy and Tabershaw report [4] describing the exposure, symptomatology and findings in chronic beryllium poisoning; the research done at Saranac [5] by the late Dr. Gardner putting chronic beryllium poisoning on a firm pathologic basis and producing the lesions in experimental animals (which work is being carried on under the able supervision of Dr. Vorwald of Saranac), we are of the opinion that industrial beryllium poisoning is well established without a perusal of other literature, most of which is sketchy, and of little significance.

In addition, the recovery of beryllium in most of the organs of Case 4 in sufficient amounts to suggest a possible lethal dose, (so necessary in the courts to establish that death was due to a poison) allows us to complete the postulates used in medicolegal work.

The following information is necessary to prove death was caused by poison:

(1) Exposure to the poison.
(2) Symptoms compatible with what is known to occur in such a poison.
(3) Autopsy disclosing lesions known to be produced by the poison and no other cause of death found.
(4) Toxicologic recovery of the poison in the organs in lethal amounts.
(5) And, if necessary, the production of the lesions in experimental animals.

5. Gardner, L. U.: Page 89 of the November 1946 *Transactions of the Eleventh Annual Meeting of the Industrial Hygiene Foundation.* Also personal communication to the senior author from Dr. Gardner.

OCCUPATIONAL BERYLLIUM POISONING

Beryllium, a light fairly expensive metal, was first isolated in the form of its oxide in 1798, but only during the early years of World War II did its great industrial importance become apparent. Since then, because of its valuable metallurgic properties in resisting corrosion, fatigue, and greatly increasing tensile strength of alloys, it has found widespread use in industry, especially in the manufacture of precision instruments and machines, alloys, phosphors, electric filaments and ceramics. It has been found to be an excellent source of neutrons in the atomic energy field. It seems likely, therefore, that there will be an ever increasing demand for its use.

Two forms of the pulmonary disease have been recognized among workers in industries using beryllium. There is an *acute form* ("Acute Pneumonitis of Beryllium Workers" —Sixth Saranac Symposium [1]) and a *chronic form* ("Delayed Chemical Pneumonitis"—Hardy and Tabershaw;[4] or "Pulmonary Granulomatosis of Beryllium Workers").

In the acute form, there is usually a short exposure period to high concentrations of beryllium compounds, a relatively rapid course with either "complete" recovery or death. In the chronic form, there is a relatively prolonged exposure period to low concentrations of beryllium compounds, a delay in the onset of symptoms (often long after cessation of exposure) and a prolonged, progressive course leading usually to irreversible pulmonary crippling and finally death from cardio-respiratory failure.

In addition to the pulmonary reactions other toxic effects have been described. Contact dermatitis and ulceration as well as chemical naso-pharyngitis and tracheo-bronchitis have been reported in the beryllium extraction industries.

INCIDENCE AND EXPOSURE

It is estimated that about five hundred cases of the pulmonary forms have occurred throughout the country as of October 1947.

Considering the vast number of workers who *reputedly* are exposed to beryllium compounds this would represent a low incidence rate.

It is noteworthy that *New Jersey has probably more industries using beryllium compounds than any other state in the country.*

Although there is considerable confusion concerning the relative toxicity of beryllium compounds, most of the acute cases have occurred in the beryllium extraction industries where workers have been exposed to high concentrations of the fumes and dusts of the sulphate, fluoride and oxyfluoride salts. The incidence and severity of the acute form are clearly proportional to the degree of exposure and chemical irritation of the dusts and fumes. There is usually a short history of exposure prior to the onset of symptoms, this exposure being often only a matter of several weeks.

Chronic cases have been encountered chiefly in the fluorescent lamp industry where workers are exposed to phosphor powders containing zinc beryllium silicate. The beryllium content of these powders has been reduced from sixteen to two percent and this may result in a lowered incidence of the disease.

In the chronic form, average exposure time before onset of symptoms has been about one and one-half years, the shortest interval being five months and the longest, five years.

In this delayed disease there is usually progressive pathology even after removal from exposure. However, several cases of slowly progressive improvement and even recovery have been reported.

In many cases, onset of symptoms has been delayed until a considerable length of time after cessation of exposure. This has varied from six months to three years after the worker left the beryllium industry. Chest films prior to onset of symptoms have not been available in most cases, but in every instance in which they were taken shortly after the onset of symptoms they have revealed marked pathology characteristic of the disease, indicating that damage is done probably long before symptoms appear. Yet much widespread confusion exists as to why the symptoms are, in many instances, delayed until a considerable time after the individual has left work in the beryllium industry and why the disease continues to progress in the absence of further exposure. If the granulomatous nature of this disease is appreciated it can easily be visualized how granulomatous cells, once stimulated by an irritant may (by over-compensation) continue to proliferate in the presence of infinitesimal amounts of beryllium embedded in the pulmonary tissues.

The "spotty" incidence of the disease in industry has been stressed and this in turn has led to confusion and has further given the disease a glow of mystery. Many investigators cannot understand why some workers with years of apparent exposure fail to develop the disease while others with comparatively little exposure are affected. However, very little is known concerning the details of the original working conditions, the details of the jobs performed and the number of individuals performing such jobs. We know of no instances in which an adequate job history is available with information concerning the number of other individuals performing the same job under the same conditions. Even in one of the most comprehensive and authoritative case reports on the disease all that is given concerning the exposure conditions is that the patients worked in "Building X". Moreover we wonder whether those industrial officials who have claimed low incidence rates of the disease have, in their statistics, presented an accurate picture of the actual number of people intimately exposed to beryllium rather than merely the total number of employees who work in the beryllium industry.

Another explanation for the "spotty" incidence of the disease may lie in the inherent defects of man himself and involve the relative degrees of intelligence, cleanliness and carefulness that exists among the workers, with the refusal of some to adhere to the recommended precautions.

Finally the integrity of the individual's respiratory system is probably an important factor. In one report, the evidence indicates that previous respiratory infections may increase individual susceptibility.

Industry is now well aware of the beryllium hazard and has been energetically engaged

in perfecting safety devices and measures. It is expected, therefore, that although additional, previously exposed cases will be recognized, a lowered incidence rate will result.

SIGNS AND SYMPTOMS

(A) Acute Beryllium Poisoning:—

Signs and symptoms of naso-pharyngeal and tracheo-bronchial irritation usually precede the onset of the pneumonitis.

There is at first, a dry cough with substernal pain. Although this pain usually disappears in one to two weeks, the cough increases in severity and becomes productive of small amounts of blood. Fine, moist, inspiratory rales are usually heard early, distributed throughout both lung fields. Several days to a week after the onset of the cough, exertional dyspnea begins which becomes progressively more severe until the patient is bed-ridden and cyanotic and requires oxygen therapy. Anorexia and weight loss are constant features.

In uncomplicated cases during the entire course of the illness there are no signs of infection. The course is practically afebrile throughout. There is no leucocytosis.

The course of the disease is rapid ending in what is reported as "complete recovery" in from five weeks to four months or in death, the mortality rates being over ten per cent. The last symptoms to disappear are usually cough and effort dyspnea.

(B) Chronic Beryllium Poisoning:—

The most constant early symptoms are anorexia and weight loss, exertional dyspnea, cough which may be either productive or nonproductive, fatigue, weakness and cachexia.

These symptoms are usually progressive and, as pulmonary fibrosis increases, pulmonary hypertension results with marked dyspnea and cyanosis. There is, occasionally, clubbing of the fingers. Cor pulmonale usually develops and is often associated with right heart hypertrophy and strain as manifested by right axis deviation in the electrocardiograms.

As the disease progresses there develops right-sided heart failure with an enlarged and tender liver, palpable spleen, ankle edema and slight ascites. At this stage continuous oxygen is required.

The course is essentially afebrile except terminally when there may be slight elevations. As in the acute form, uncomplicated cases are not associated with any laboratory evidence of infection. Sputum shows no pathogens. The globulin fraction of the plasma may be slightly elevated, but this is compatible with a chronic granulomatous disease as well as, later, with the engorged liver. Transient, intermittent rales are heard during the course of the disease, but chest findings are inconstant.

X-RAY FINDINGS

(A) Acute Beryllium Poisoning:—

Chest films are usually negative for the first several weeks after onset, but then show diffuse and bilateral changes in all instances.

There is at first a diffuse haziness, followed by soft irregular areas of infiltration with increased broncho-vascular markings. Following this, the areas of soft infiltration gradually disappear and discrete small or large conglomerate nodules are seen. There is x-ray clearing before the complete subsistence of the signs and symptoms. Slight residual fibrosis may remain in the lung fields.

(B) Chronic Beryllium Poisoning:—

Sosman and Wilson [4] (in the Hardy and Tabershaw report) have conveniently classified the x-ray findings into three states:

(1) *Stage of Granularity*—This is the most distinctive stage and there is no other disease which even closely mimics the appearance of the lungs in this stage. Small, finely particulate granulations are seen diffusely throughout each lung field. These have the appearance of fine sandpaper; and when seen under a magnifying glass resemble a "sandstorm".

(2) *Stage of Reticulation*—In this stage a reticular pattern is superimposed on the granular background. There may be slight fuzziness and enlargement of the hilar areas.

(3) *Stage of Nodulations* — This is the phase which is most likely to be confused with other diseases; for this stage closely mimics sarcoidosis, carcinomatosis, erythema nodosum and miliary tuberculosis.

In this stage there are distinct nodulations up to 5 millimeters in size which do not calcify, cavitate or coalesce and create the appearance of a

"snow-storm". The hilar areas may appear even more fuzzy and prominent. Prominent cor pulmonale with right-sided cardiac enlargement may be noted in this stage.

Although this is a convenient classification, it has been noted, that the most severe type of pulmonary crippling with extreme fibrosis, marked pulmonary hypertension with cor pulmonale and right-sided cardiac enlargement may occur with the chest film findings typical of the stage of reticulation. Conversely, individuals who have chest films typical of the stage of nodulations may be far less crippled. Consequently, the contour of the heart (cor pulmonale, right-sided enlargement) is a good index of the degree of pulmonale crippling present. Areas of compensatory emphysema may be noted in most cases. Spontaneous pneumothorax, however, is unusual.

DIFFERENTIAL DIAGNOSIS

(A) Acute Beryllium Poisoning:—

This form of the disease may be confused with viral and bacterial pneumonias, including tuberculosis, as well as with pulmonary carcinoma. However, a history of exposure to beryllium compounds, the course and findings as above described, and the usual absence of signs of infection should strongly suggest the diagnosis. A test for beryllium in the urine has been recently developed by the Kettering Laboratory and this will probably prove to be of distinct value.

(B) Chronic Beryllium Poisoning:—

Sarcoidosis, carcinomatosis, miliary tuberculosis, erythema nodosum, silicosis and other pneumoconioses have all in the past been confused with this form of the disease. Again the history of exposure to beryllium compounds, the usual absence of signs of infection, the course and findings as above described should strongly suggest the diagnosis. If the patient is in the stage of granularity (which is the most characteristic phase of the disease), when the x-ray findings are so distinctive that there is not even a faint resemblance to other diseases so far known, the diagnosis should be made with almost absolute certainty if the patient has been exposed to beryllium.

PROPHYLAXIS AND TREATMENT

Prophylaxis against both forms of the disease includes the use of safety devices and rigid measures to protect the workers from exposure to the fumes and dusts of beryllium compounds.

There must be good housekeeping and strict selection and supervision of workers.

Protective devices include adequate work clothing, air masks, exhaust fans, furnace shields, shields for job benches, etc.

Dust counts (which have been made largely since control measures have been instituted) have all been low and have been considered as not hazardous.

Pre-employment chest films and subsequent, frequent, periodic films should be routine.

Because weight loss is such a constant feature in both forms of the disease monthly weight records are valuable.

TREATMENT OF ACUTE BERYLLIUM POISONING

Naso-pharyngitis should be regarded with a certain degree of alarm for if it is due to beryllium exposure it may be the precursor of chemical pneumonitis. When workers develop naso-pharyngitis, the prophylactic measures in use should be carefully checked in order to detect any defect in the protective chain. Usually chemically naso-pharyngitis clears promptly if complete protection from exposure is achieved.

Tracheo-bronchitis should be regarded with even more alarm, and, if felt to be chemical in origin, complete bed-rest should be mandatory; for without complete bed-rest recovery is usually delayed or progression to pneumonitis occurs.

The treatment of chemical pneumonitis during the acute phase is absolute bed-rest and oxygen therapy. Following the acute phase the patient's activities should be greatly restricted in the home until *all* signs and symptoms disappear. Early exertion may precipitate a fatal attack of acute pulmonary edema. Other therapeutic measures are of doubtful value. Chemotherapy may be employed prophylactically or if there is evidence of secondary infection, but does not influence the course of the disease in uncomplicated cases. If pulmonary edema

develops the usual methods of treatment should be instituted.

Contact, chemical dermatitis has been encountered frequently in the extraction industries. It has been noted that these workers have been especially prone to the acute pulmonary disease if allowed to continue their work. These employees should not be allowed to work in the beryllium industry.

TREATMENT OF CHRONIC BERYLLIUM POISONING

Treatment is largely supportive in nature. Complete bed-rest, oxygen and digitalis may be necessary later in the course of the disease.

No drug has proved to be of any specific value to date. Nitrogen mustard therapy has recently been shown to have some beneficial effect in sarcoidosis. Since the pathology of the chronic form is almost identical to sarcoid this therapy suggests itself here. The use of British Anti-Lewisite ("B.A.L.") would probably have no effect because beryllium is a light metal.

Some regression of the pathology and relief of symptoms have been noted following radiation therapy of the chest when it was tried in several cases which were at first thought to be due to carcinomatosis.

COMPENSATION ASPECTS

One of us (HSM)[6] in 1929, made the following statements after an investigation of the radium poisoning deaths in dial painters:

"It was stated by Sir Thomas Oliver on his recent visit to this country that in northern New Jersey there was a larger number and variety of industries in which occupational poisoning could exist than in perhaps any other known geographic area in the world. In this location new industries are constantly appearing in which new chemical, physical and other hazards are becoming apparent. It is most important, therefore, that the compensation laws of the state should be so elastic as to include at any time new and hitherto undescribed forms of occupational poisoning. It is only fair to the employees and the employer that such compensation laws should be formulated. In the cases of the dial painters it is an unfortunate and sad situation that more than fifteen deaths occurred, in only two of which did the families receive any financial aid; and that some fifty girls have spent almost their entire earnings for years on dental bills and sickness. It is unfortunate that because of the lack of protection by compensation, the plant had continually to ignore responsibility and to fight every step in the courts to prevent financial ruin. This is not a fair deal for either side."

Since radium poisoning was not listed in the compensation laws of New Jersey at that time, none of the radium victims could obtain compensation and five were forced to take civil action. After years of wrangling these cases were settled out of court and all future court action was stopped by the Supreme Court of New Jersey, which denied even civil action on the basis of the Statute of Limitations since their disease did not manifest itself until two years after the victims had left their occupation, and no claims had been entered. This was a ridiculous and uncivilized attitude.

Nothing has been done since 1929 except to add to the original nine industrial diseases (for which compensation could be awarded), mesothorium or radium poisoning, dermatitis venenata (industrial dermatoses), silicosis and asbestosis, the latter by a special amendment. Except for the civil courts, there is no other redress for the worker ill or dying as the result of an industrial disease or poisoning not mentioned in the New Jersey compensation laws.

The remedy to this unfortunate situation would be comparatively simple with an all-inclusive occupational disease compensation law with a revision of the Statute of Limitations. It is unfair to wait for proved deaths and industrial cripples before the legality of a new industrial disease is established. Why should industry be saddled by having to pay premiums on two forms of insurance, liability and compensation?

The question which arises is: "Did the disease appear during the course of, and as a direct result of employment?" If the answer is in the affirmative, the sufferer or his family should be compensated by law.

Absurd compensation claims for the usual medical diseases, (the etiology of which has no bearing on the type of employment), could easily be nullified under an all-inclusive occupational compensation law and an adequate medical screening board.

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TREATMENT OF UNDULANT FEVER WITH STREPTOMYCIN

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Undulant fever is a stubborn disease, resistant to almost all therapy. During the past eight years numerous papers have been written on the use of the sulfonamides in the treatment of this disease. Reports have been conflicting. In 1938, Haden [1] cited a case of brucellosis treated with sulfanilamide, 20 grains every four hours. The sulfa concentration in the blood ranged from 7 to 19.5 milligrams per cent. The temperature returned to normal in one week. Bynum [2] in 1939 reported two cases of acute, one of subacute, and three of chronic undulant fever all treated with maximum doses of sulfanilamide without satisfactory results. In 1940 Lincoln [3] had good results with a 60 year old patient, whose recovery promptly followed treatment with increasing doses of brucella vaccine in conjunction with neoprontosil. Simpson [4] concluded that sulfanilamide and other sulfonamide drugs were of little benefit. In 1941 King and Lucas [5] using sulfapyridine in experimental brucellosis in guinea pigs found that this drug did not cure, or even control brucella infections in that animal. Winters, Ward and Bach [6] reported a fatality in spite of maximum doses of sulfanilamide. Hartsock [7] had a similar experience. In 1942 Sarvis [8] reported four cases using sulfaguanidine with improvement in all. He felt this to be a good agent and recommended its use. Arnold, Hershey and Lascara [9] after trying various types of treatment favored vaccine therapy. Mable [10] reporting four cases, concluded that artificial fever therapy and sulfanilamide plus vaccine gave most consistently favorable results. Davis [11] reporting in 1942 failed to see good results from sulfanilamide, sulfapyridine or sulfathiazole. Nor did he advise shock therapy, since he feared the very severe reactions which resulted and the lack of favorable results afterwards. Davis [11] preferred vaccine therapy, though he recognized that certain stock vaccines are very dangerous, since some patients develop allergies to the protein of brucella. Carpenter [12] felt that immune serum should be limited to the early stages of the disease when toxemia and bacteremia are present. He advised that nearly all vaccines are toxic and should be used with caution.

Urschel [13] in 1944 reviewed the treatment in 195 cases. He found complete success in 56.9 per cent and complete failure in 27.7 per cent. In 15.4 per cent there was initial success with later relapse. This study did not include sulfadiazine or later derivatives. Urschel [13] concluded that the actual proportion of successful therapy is no higher than might be expected from untreated cases and that the value of sulfanilamide therapy in brucellosis is doubtful. Staub [14] had similar results. In 1945, Spink and Hall [15] emphasized the fact that such chemotherapeutic agents as methylene blue, mercurochrome, acriflavine, methyl violet, metaphen, neoarsphenamine, neosalvarsan and atabrine, had been tried without good results. They felt that sulfa was of definite value in acute cases. However they found that bacteremia persisted during the immediate afebrile convalescent period of brucella suis. Of eight patients with bacteremia due to *brucella abortus* all were sterilized except one who had brucellar endocarditis. Harris [16] felt that sul-

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fadiazine and sulfathiazole were of value but not curative in acute cases. In chronic cases he advocated vaccine from the *abortus* strain, getting 75 per cent satisfactory results in 400 cases. Of 97 cases treated with "brucellin" by Benning [17] in 1946, seventy improved, eight were unimproved and the remainder could not be followed properly. Recently, Gaetz [18] reported a case that failed to respond to penicillin and sulfamerazine but improved promptly with streptomycin. The patient received 65,000 units every three hours intramuscularly for a total of one million units.

Harris [19] discussing advances in treatment feels that streptomycin is effective in terminating the acute illness with resultant negative cultures but that relapse usually follows. Of 45 cases reported by Keefer [20] treated with streptomycin, thirty showed improvement. Twenty have been followed for three to eight weeks and there have been two relapses. It was felt that no dramatic effects were observed on the course of acute brucellosis.

CASE REPORT

A 48 year old white male was admitted to the general medical service of the Jersey City Medical Center on June 5, 1946. He gave a history of diurnal rise in temperature associated with headache, sweating and anorexia of nine days' duration. Because of the persistence of these symptoms and, later, the development of marked weakness, he came to the hospital for assistance. His occupation was that of a stockyard worker unloading cattle and pigs, his main job being to locate and dispose of animals found dead on arrival.

The patient appeared very toxic. There was marked diaphoresis. Temperature was 102, the pulse was 100, and the respirations were 28. Examination of the head, neck, heart, lungs, abdomen and extremities was essentially negative. Blood pressure was 120 systolic and 75 diastolic.

Red blood count was 4,8 million per cubic millimeter with a 90 per cent hemoglobin. White blood count was 7,850 with 70 per cent polymorphonuclear leucocytes. The Wassermann was negative, blood sugar 78 milligrams per cent and blood non-protein nitrogen 26 milligrams per cent. A chest x-ray and electrocardiogram were within normal limits. A blood agglutination series revealed a 4-plus reaction for undulant fever at 1:320. Blood cultures on the third, fifth and seventh hospital days all were positive for *Brucella suis*. On the eighth hospital day, temperature rose to 105.4 and the patient became delirious. On the tenth hospital day, temperature was 105.8. At this time, he appeared almost moribund. Streptomycin was first used on the tenth hospital day. The patient received four grams daily (4,000,000 units). He received 500,000 units every three hours intramuscularly. This resulted in prompt improvement. Temperature began to fall and reached 99 by the seventeenth hospital day. Blood cultures taken the eleventh, thirteenth, fifteenth, sixteenth, seventeenth, nineteenth, twenty-third, thirtieth, thirty-seventh and forty-fourth hospital days were all sterile. On the eighteenth hospital day, the temperature rose suddenly to 103.8, and remained elevated until the twenty-fourth hospital day at which time the streptomycin was discontinued. Within two days the temperature had returned to normal. To determine whether the temperature elevation had been caused by the antibiotic, streptomycin was again administered on the twenty-seventh hospital day and continued for four days before it was stopped again. There was a telltale rise in temperature to 103 within 48 hours and this abruptly dropped to normal following discontinuance of streptomycin and remained there until the time of discharge on the forty-eighth hospital day.

Following discharge he was observed at frequent intervals in the general medical clinic and later at my office. Blood cultures taken monthly since discharge, have all been sterile. The patient was last examined ten months after hospital discharge and was found to be in good health.

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TREATMENT OF PEPTIC ULCER WITH CASEIN HYDROLYSATE

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Recent reports [1, 2, 3, 4] on the treatment of peptic ulcer with a hyperalimentation regime of a high caloric and high amino acid (protein hydrolysate) mixture, have been so promising and the method of administration so simple and economic as to invite more general application in the ulcer patient.

Amino acid mixtures had been found by Levy and Siler [5] an effective buffering agent when introduced into the stomach and were for this reason recommended by them in the clinical management of peptic ulcers. Riggs and his co-workers [6] observed significant nutritive deficiencies in a group of 52 peptic ulcer patients, and on the basis of their studies stressed the importance of adequate nutrition in the prevention and treatment of ulcer. Co Tui [2] et al.[7] demonstrated by means of nitrogen balance studies that the ulcer patient is usually in a state of protein depletion. Upon hyperalimentation treatment with protein hydrolysates, striking clinical improvement and an increase in strength and body weight were found.

The use of suitable hydrolysates of protein in peptic ulcer is based upon three points: (1) Some protein hydrolysates, which contain all the essential amino acids, are a rich source of nutriment and can be utilized in the protein depleted body to maintain a positive nitrogen balance, and so aid in the repair of such tissue defects as are seen in peptic ulcer. (2) They are strong antacids and so are expected to give symptomatic relief when pain is due to hyperacidity. (3) Such predigested protein imposes less of a digestive task on the gastrointestinal tract.

Although only a comparatively small number of peptic ulcer patients were treated by us, the desirability of accumulating more data on the efficiency of such hyperalimentation treatment prompts us to report our own experience. We have used a casein hydrolysate * in our peptic ulcer patients during the past year with excellent results. Fifteen patients were treated, and in fourteen of them, the regime was a clinical success. The fifteenth has had several relapses and is at present hospitalized for further treatment.

The patients were submitted to physical examination and x-ray, their history and habits established, and were then immediately put on the hyperalimentation regime. A casein hydrolysate was prescribed for each patient on a weight basis (about two grams of hydrolysate per pound of body weight). Calories were added in the form of dextromaltose in an amount at least equal in weight to the hydrolysate, giving a total caloric intake of about 16 to 20 calories per pound. The hydrolysate and the dextromaltose were each suspended in one pint of water and mixed.† The total amount was divided into eight feedings, given every two hours from 7 A. M. to 9 P. M. Fresh fruit juices were allowed to mask the taste if desired. Vitamins were supplied in sufficient amounts. Minimum mineral requirements are contained in the casein hydrolysate. Abatement of pain and lessening of discomfort usually followed the first few feedings. The strength of the patients increased gradually, they felt much better and usually gained in weight. The diet was continued for from 14 to 21 days, or longer if necessary. Casein hydrolysate was then partly or completely replaced by a bland diet with an eventual gradual return to normal diet. Patients were however, cautioned about former dietary indiscretions as a return to these is likely to bring a recurrence of symptoms.

The following cases illustrate our experience.

CASE ONE

A 39 year old male complained of epigastric pain for three years. He vomited frequently during the past two weeks, had severe sharp knife-like pains in the epigastrium and finally was unable to continue his work. An x-ray examination revealed a "cap ulcer" and hypermotility of stomach, intes-

* The product used was Casein Hydrolysate, Squibb. This is an enzymatic hydrolysate of casein characterized by cleavage of 25% of the peptide linkage.

† The mixture should be made up fresh daily and kept chilled.

tines and colon. He was given 320 grams of casein hydrolysate per day with an equal amount of dextromaltose, mixed and divided into eight feedings. Two days after starting the treatment, the patient was much better, and 21 days later he felt "perfect". Two of the hydrolysate feedings were now replaced by two feedings of a bland diet. He continued to feel well. Four weeks later he was put on a soft diet and soon after returned to work. He was now able to tolerate without untoward incident his alternating day and night shifts. A follow-up after six months showed him feeling and sleeping well and having gained strength and weight. Except for fried or greasy foods, he is now eating a regular diet. X-ray examination nine months after beginning of treatment still shows evidence of chronic cap ulcer but inasmuch as scar tissue may be the cause of the deformity of the duodenal cap, it is difficult to determine radiographically whether there is an active ulcer still present or not. However, clinically there has been a complete cure.

CASE TWO

A male, 35 years old, discharged from the Merchant Marine, complained of epigastric distress which he had had for nine months. He thought it was brought on by excessive alcohol intake while he was on duty in the Pacific. X-ray examination showed a small "cap ulcer" and hypermotility of stomach, intestines and colon. He was placed on casein hydrolysate, 360 grams per day with 360 grams of dextromaltose and the usual vitamin supplementation. He immediately became symptom-free. Twenty-four days later three of the hydrolysate feedings were discontinued and fourth week Sippy diet feedings substituted for them. This was continued for eighteen days. Another x-ray revealed that the ulcer noted on the previous occasion was no longer present. The patient felt well and showed definite gain in strength and weight. He was returned to a regular diet with the caution that he abstain from alcohol and tobacco and from highly seasoned or fried foods.

CASE THREE

In this 22 year old patient, distress began while he was with a tank battalion in Europe. At that time his diet was irregular and insufficient. Symptoms became progressively worse, with marked irregular bowel habits. X-ray showed a "cap ulcer". He was started on casein hydrolysate and after one week felt entirely well. His bowels were regular, and he gained in weight and strength. Three weeks later he was placed on three meals of Sippy diet with five hydrolysate feedings remaining. X-ray two months after starting treatment still revealed evidence of "cap ulcer" without much change since the previous examination. Twice he had had mild discomfort not related to eating. Weight and strength remained unchanged. He was returned to straight hydrolysate feedings, three weeks later again to supplemental Sippy diet for one week and then on bland diet. Clinically he seemed entirely cured. X-ray now shows no definite evidence of "cap ulcer".

CASE FOUR

A 31 year old male complained of pain in the epigastrium for a period of about six months. There was definite x-ray evidence of gastric ulcer. Casein hydrolysate mixed with dextromaltose and vitamin supplements were prescribed and taken as the only source of nourishment for fourteen days, and for the following seven days the hydrolysate was then given between regular meals. Forty-eight hours after beginning of treatment the pain stopped completely, the patient felt well except for being moderately weak and very thirsty. He continued at work, and there was a considerable gain in weight noticeable. Observation is continued but patient has not complained of any difficulties since beginning of treatment.

CASE FIVE

A 37 year old male had been hospitalized three months before this attack, for bleeding peptic ulcer. He suffered periodic severe attacks of gastric distress which were always related to the ingestion of food. X-ray examination established a positive diagnosis of pre-pyloric ulcer. Treatment with casein hydrolysate was started at a ratio of 4.4 grams per kilogram of body weight. To this, we added dextromaltose and vitamin supplements. This was continued for fourteen days with feedings at two hour intervals, eight feedings being given daily. The gastric pain stopped completely after forty eight hours. The patient's weight increased from 151 to 159 pounds in fourteen days. He felt clinically fine and to this date remained symptom-free.

At first, most patients object to the taste of the preparation. However, it is generally well tolerated, and causes neither nausea nor vomiting. Most patients are able to continue at work during treatment. This obviates the economic loss necessitated by bed rest in the conventional ulcer regime.

PROTEIN REGENERATION

The plasma protein concentration of patients with peptic ulcer is lower than that of normal subjects.[6] One of the beneficial effects of protein hydrolysate therapy is its ability rapidly to repair tissues or regenerate proteins. Presumably this occurs as the result of a sustained positive nitrogen balance, an effect which is possible only when adequate amounts of all the essential amino acids are administered.

Several patients were selected for the study of plasma protein regeneration in order to evaluate the ability of the hydrolysate used to promote this desirable effect. Electrophoretic analyses were performed on the plasma of all

ulcer patients before and after a period of oral administration of casein hydrolysate to ascertain whether the dietary regimen promotes plasma protein regeneration in the ulcer patient and if so what fraction or fractions are affected. The results of a typical analysis of two samples of plasma taken from the patient in case two are:

The figure shows the descending patterns of samples of plasma taken before and after treatment. The area under each component is a measure of its relative concentration and the composition expressed in per cent is given in Table I. The albumin: globulin ratio was normal before treatment and remained so after the administration of casein hydrolysate. Determinations of concurrent plasma volume permits the calculation of the total amount of each of the protein components in circulation. These results, summarized in Table II, indicate a gain of 19 grams of proteins, ten of which are albumin and nine of which are globulins.

All patients in the series showed a similar increase of total circulating albumin and globulin. The amount of protein regenerated was as small as 4 grams and as large as 25 grams. These data are important in that they are indicative of a sustained positive nitrogen balance in all patients.

TABLE I

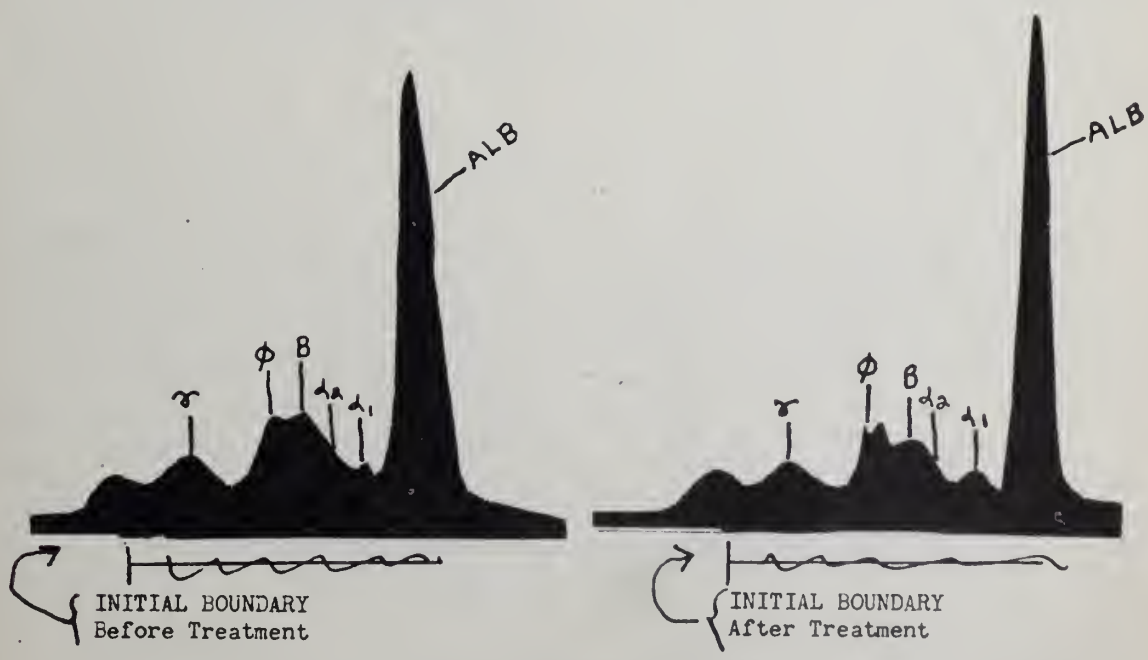
	Before Treatment	After Two Weeks
Albumin	5	55
Alpha 1 globulin	3	6
Alpha 2 globulin	4	5
Beta globulin	15	7
Fibrinogen	10	13
Gamma globulin	13	14

COMPOSITION OF PLASMA IN PERCENT, CASE TWO

TABLE II

	Before Treatment	After Treatment	Increase
(A) Plasma protein concentration, gram per cent	7.13	7.25	0.12
(B) Plasma volume in cubic centimeters	2960	3170	210
(C) Circulating protein (A x B) in grams	211	230	19
(D) Circulating albumin in grams (C x % albumin)	116	126	10
(E) Circulating globulin in grams (C x % globulin)	95	104	9
(F) Circulating plasma protein in grams:			
(1) Alpha 1, globulin	6	14	8
(2) Alpha 2, globulin	8	12	4
(3) Beta globulin	32	16	−16
(4) Fibrinogen	21	30	9
(5) Gamma globulin	27	32	5

CHANGES OF TOTAL CIRCULATING PLASMA PROTEINS AFTER TWO WEEKS OF CASEIN HYDROLYSATE TO PATIENT, CASE TWO.



ELECTROPHORETIC ANALYSIS OF PLASMA OF PATIENT (CASE 2) BEFORE AND AFTER ORAL ADMINISTRATION OF CASEIN HYDROLYSATE

COMMENT

The results which we have just described, confirm the findings of previous workers. The administration of casein hydrolysate brought about symptomatic as well as x-ray relief of patients with peptic ulcers. Although a nitrogen balance experiment was not performed, the regeneration of plasma proteins by all these patients indicate that there was nitrogen retention. We appreciate that these results are with a specific hydrolysate * characterized by (1) partial cleavage of the peptide linkages to the extent of 25 per cent, (2) adequacy of essential amino acids in dosages given, thus permiting sustained positive nitrogen balance, and (3) significant amount of strepogenin.[8] Other hydrolysates with comparable characteristics would presumably have produced a similar effect. However, the importance of each of these three characteristics can not be decided on the basis of the data available.

SUMMARY

Fifteen patients with peptic ulcer were treated with a casein hydrolysate. Fourteen were clinically cured or greatly improved. Casein hydrolysate, in addition to rapidly regenerating plasma proteins and repairing the tissue defect in the ulcer, appears to act as a natural antacid.

The protein depletion existing in the ulcer patient responds successfully to hyperalimentation with casein hydrolysate. The change in plasma protein constituents is plainly visible in the electrophoretic pattern. Total circulating protein is increased. The changes parallel clinical improvement.

A high protein-high caloric diet appears to be an improvement over conventional methods generally in use. The predigested protein is well tolerated in the gastro-intestinal tract, easily digested and brings prompt relief. Clinical improvement is usually noticeable after a few feedings and gain in strength and weight follow gradually. The economic saving resulting from being able to continue at work is a factor of considerable importance.

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PREVENTING ORCHITIS IN MUMPS

In adults with mumps, chances of gonadal involvements are lessened by use of convalescent serum. Among 249 sailors with mumps, orchitis developed in only 14 of 86 given 40 cc. of convalescent serum each, intravenously, reports Alwin C. Rambar. Orchitis occurred in 47 of of 163 patients not given serum prophylaxis, an increase of 75% in incidence. Results of treatment were less spectacular. Of 26 patients with orchitis given convalescent serum and pooled plasma, fever subsided within three days in 16. Of 30 control patients, duration of fever was similar in 10 and longer in 20—Am. J. Dis. Child, 71:1.

PEPTIC ULCERS IN AVITAMINOSIS

Peptic ulceration may be encouraged by thiamin deficiency. Gastric hypersecretion consequent upon thiamin depletion is the mechanism favoring ulcer formation, believe Shay and associates of the Samuel S. Fels Fund. Spontaneous gastric secretion is greatly increased in rats when thiamin chloride is withheld until body weight falls 30% and signs of polyneuritis appear. Incidence and severity of gastric lesions in such animals are much higher than in rats supplied adequate vitamins.—Gastroenterology 6:199.

WILMS' TUMOR

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Wilms' tumor of the kidney (embryonal adenoma-sarcoma) is found predominantly in young children, usually before the fourth year of life, although there is one case reported in the Mayo Clinic series in a patient 59 years old.

Owing to the age of the patients, no definitive symptoms are discernible at first and whatever symptoms are present are not usually referable to the kidney, until a lump in the side is discovered by the parent. Fever and abdominal pain are next in frequency.

Since the outcome of these tumors is usually unfavorable, the following case with a five year follow-up without recurrence seems worth reporting.

CASE REPORT

An eight months old female child was admitted to the hospital with a history of loss of weight, refusal of feedings and the presence of a mass which filled the entire left side of the abdomen. She was studied on two occasions; during the first of these the mass was diagnosed as a large spleen; but the diagnosis of kidney tumor was definitely established during the second period.

In June, 1941, a transperitoneal nephrectomy for tumor of the left kidney was performed. A transfusion of 200 cubic centimeters of blood was given during operation. At the conclusion of the operation, the general condition of the patient was excellent.

The examination of the specimen and the diagnosis of Wilms' tumor was made by Dr. Felsen: Section of the tumor showed a cellular growth composed chiefly of spindle cells among which were interspersed a number of oval or irregular empty spaces lined by flattened epithelium, low cuboidal epithelium or occasional columnar epithelium. True tubules, such as are ordinarily seen in the kidney, were not visible in the sections examined, and some of these empty spaces were lined partly by low columnar and partly by flattened cells. In one place there was an invagination of the spindle cells into one of these tubule-like areas, suggesting abortive renal structure. The spindle cells were generally uniform in shape and disposed in long sheets or waves, many exhibiting marked hyperchromatism. The picture was that of an embryonal adenomyosarcoma, but it was difficult in many areas to differentiate the connective tissue from the smooth muscle elements. No striated muscle was seen. Diagnosis: Wilms' tumor.

Postoperative course was uneventful. During the hospital stay the child received radiation therapy. Her condition on discharge was excellent.

Two weeks after discharge from the hospital, she was readmitted for an acute intestinal obstruction. This was relieved by operation, and, although convalescence was stormy, the patient finally recovered and was discharged from the hospital in good condition.

Postoperative irradiation therapy was continued at the Memorial Hospital. The patient was followed regularly and there was no evidence of any recurrence or metastases of the tumor at any time.

In June, 1945, the patient developed pulmonary asthma with emphysema. A bronchoscopy was refused by the parents; and the patient was then taken to Arizona where she now lives. A communication from the local physician says that in February 1947, the child had another severe asthmatic attack but, almost six years after the operation, there was still no evidence of any tumor recurrence.

DISCUSSION

The origin of Wilms' tumor (embryonal adenomyosarcoma) is debatable and the present status is as follows: (a) the tumor originates at different developmental periods of the embryo; (b) the nephrotome is a predominating contributing structure and a tumor anlage; (c) there may be multiple tumor cells if the tumor anlage separates before formation of the nephrotome. This may account for the presence of muscle fibers and other tissue in the tumor. Gross examination of a Wilms' tumor may show it to be solid, cystic, or necrotic. The mass is well demarcated and surrounded by a fibrous capsule. The surrounding kidney is thinned and shows pressure changes due to the tumor. The center of the tumor is gelatinous with strands of muscular, glandular or cellular tissue. Metastases are generally hematogenous in origin, and the common sites for the latter are the liver, lungs and bones.

The predominating microscopic feature of a Wilms' tumor is its embryonal nature, and the demonstrable tissue must involve ectoderm and mesoderm, and include nephrotome, sclerotome and myotome.

TREATMENT

Considering the number of cases which have been observed, the treatment of Wilms' tumors

has been discouraging. Many different measures have been used including (1) irradiation, (2) operation, (3) irradiation followed by operation, (4) operation followed by irradiation, and (5) irradiation followed by operation and subsequently by postoperative irradiation.

It is my belief that the last type of treatment is most effective. In the opinion of most observers, irradiation alone is not adequate treatment for Wilms' tumor. Indeed, Priestley and Schultze [1] found viable tumor cells in the operative specimen after a preliminary course of irradiation. Evidently the tumor cells are not destroyed completely by roentgen therapy.

The longer operation is postponed, the greater is the possibility of metastasis. This is the one danger of preoperative irradiation. Should the latter be done, nevertheless, the optimal time for operation would be the interval between definite maximum decrease in the size of the tumor and before secondary enlargement has appeared. The danger in the latter criterion is obvious. In addition, if this plan is followed, one must recognize that the growth is almost always found to be more extensive at the time of surgical exploration than was previously suspected.

Ockerblad and Carlson [2] suggest one possible technical use for preoperative irradiation: in the event of extreme size of the tumor, radiation may be useful in exceptional instances to diminish the tumor size and thereby technically facilitate nephrectomy.

RESULTS

The literature contains reports of 30 cures following the removal of Wilms' tumor. Thirteen of the patients were followed for five years or longer. Ockerblad's case [2] was followed for eight years. Patients who survive for a year or two following operation are usually considered cured, although Abbe reported a case in which a sarcoma developed in the remaining kidney four years following the first operation. The age of the child seems to bear no relation to the anticipated cure and the type of tumor is similarly without significance.

12 E. 87th Street

1. Priestley, J. T., and Schultze, T. L.: Journal of Urology. 47:7 (January 1942).

2. Ockerblad, N. F., and Carlson, H. E.: Journal of Urology. 50:265 (March 1945).

PLASMA FOR POLYCYTHEMIA

Patients with polycythemia vera are improved by large venesections immediately followed by plasma transfusion. In successfully treating 8 of 9 patients, Widstrom and Swedberg withdrew up to 1,500 cc. of blood in less than thirty minutes. The operation may be repeated at short intervals. Immediate replacement of plasma results in favorable corpuscle-plasma ratios. Acta med. Scandium, 124:421.

TUBERCULOSIS AND THE GENERAL HOSPITAL

The general hospital plays a major role in the organization for the fight against tuberculosis inasmuch as it offers facilities necessary to tie together the agents of research, prevention and treatment. But many general hospitals refuse admission to patients afflicted with pulmonary tuberculosis and even insist upon the removal of patients whenever diagnostic study discloses the presence of this disease. Public health education has accomplished much by way of removing the barriers of prejudice which formerly restrained general hospitals from accepting tuberculosis patients and modern methods in the control of infection have made possible a certain degree of intercommunication among patients with various types of illness without danger of cross-infection.—Hospital Survey News Letter, Feb., 1947.

HOARSENESS *

F. Johnson Putney, M.D., Philadelphia, Pa.

Hoarseness is a warning not to be ignored. It is a symptom which, when neglected, overlooked or temporized with, may lead to a hopeless endstate. Hoarseness denotes interference with the phonatory function of the larynx, the cause of which may lie in the larynx itself or in some other organ or system. Hoarseness is easily detected simply by listening to the voice. The patient, his family or friends are usually the first to notice any change. The symptoms are significant in arriving at the correct diagnosis of any pathologic condition, but proper interpretation by the physician is essential. Examination of the larynx, by mirror or direct laryngoscopy, or both, is mandatory to determine the cause of hoarseness, and, when an abnormality exists, proper measures to find out its nature are necessary. The larynx should receive as meticulous an examination as any other portion of the body. At times, the services of a physician especially proficient in the diagnosis and treatment of laryngeal disorders are required. Vocal fatigue may precede or accompany hoarseness, and the temporary lessening of the dysphonia resulting from vocal rest sometimes is misleading. Most tumors arise in the anterior portion of the larynx, and both time and skill may be needed to visualize this area completely.

Production of a normal voice is dependent on proper function of the larynx, the resonators and articulators. A vibrating column of air is set in motion by the larynx, and, as this air passes through the pharynx, nose and sinuses on expiration, the sound becomes more resonant, enabling the mouth, lips and tongue to form clearly enunciated words. Differentiation of voice changes brought about by interference with the resonating and articulating mechanism from those produced by hoarseness of laryngeal disease must be made. Examples of modifications of speech and voice originating from faulty articulating and resonating mechanisms are nasal or pharyngeal obstructions, limitation of the tongue movement from either inflammatory or neoplastic lesions, palatal paralysis and congenital cleft palate and hare-lip.

The general term, hoarseness, as used here, embraces all alterations of the voice contingent on laryngeal abnormalities, including the various gradations, as huskiness and aphonia. The first symptom of a general systemic disease may be manifested by disturbances in the larynx, producing hoarseness. The cause may lie at a distant point, but a definite lead can often be obtained from the pathologic change in the larynx.

The underlying cause of hoarseness must be found early to insure adequate therapy. Delayed diagnosis results from one of the following: (1) failure of the patient to consult a physician soon enough, (2) omission of a laryngeal examination by the physician, or (3) inability of the physician to visualize or recognize a lesion in the larynx. Implication of the physician is present in two instances, while responsibility rests with the patient in only one. The patient may receive treatment for a condition not related to the hoarseness, thereby losing valuable time in arriving at the correct diagnosis. Useless operations on the nose, throat and sinuses can be avoided if primary attention is focused on the larynx. Delay proves serious, if diseases such as carcinoma and tuberculosis are present. Too often in laryngeal malignancy, the patient when first seen has a growth outside the laryngeal box or one so extensive as to require total removal of the voice-box. A diagnosis of chronic laryngitis is justifiable only after all other causes for hoarseness have been ruled out. This may entail laboratory, medical, neurologic, or roentgenologic examinations in addition to laryngeal examination.

ETIOLOGY

The causes of hoarseness are numerous and complex. The more common local laryngeal conditions are tumors (malignant and benign), granulomata, acute and chronic inflammations

* Read by invitation, Annual Meeting, The Medical Society of New Jersey, April 23, 1947.

and infections, polyps, vocal nodules, keratosis, injuries, syphilis and tuberculosis. In most of these laryngeal disturbances, histologic study is indispensable in arriving at the correct diagnosis, and is the most important single examination. Hoarseness may be due to general diseases or to central nervous system causes, for any lesion affecting the vagus nerve or its laryngeal branches may produce hoarseness. Systemic causes include aortic aneurysm, carcinoma of the trachea or bronchus, carcinoma of the esophagus, mediastinal metastases, tuberculosis, thickened pleura, carcinoma of the thyroid, cardiac disorders, blood dyscrasias, and allergy. Diseases of the central nervous system and toxic neuritis, resulting from lead poisoning, diphtheria, and certain acute virus diseases, are additional causes of hoarseness.

Congenital lesions of the larynx manifested by hoarseness include webs, cysts, stenoses, and congenital laryngeal stridors. They usually produce symptoms early in life, and, when marked, may cause great distress. In these instances obstruction is usually a prominent feature.

In hoarseness coming on acutely and abruptly, marked edema and inflammation of the glottis is frequently observed. This may be induced by inhalation of irritating vapors, acute infectious diseases, such as, septic laryngotracheobronchitis, injuries or wounds, foreign bodies, and perichondritis. Acute laryngitis follows many colds, and children are especially prone to develop spasmodic laryngitis with respiratory infections. Infectious laryngitis and diphtheria cannot be overlooked in hoarseness associated with an acute febrile reaction.

The main laryngeal tumors arise from epithelium, while the underlying supporting tissues contribute relatively few new growths. By far the most frequent site of laryngeal involvement in both benign and malignant tumors is the vocal cord.

Benign tumors produce early, rapidly increasing huskiness, along with an unstable voice and easy voice fatigue. The common benign neoplasms, causing hoarseness by interference with accurate vocal cord approximation, are papillomas and inflammatory lesions, which are not true neoplasms but have been variously designated as angiomas, fibromas, and polyps. Two types of papillomas are recognized: (1) those occurring in adults, which may be either single or multiple, villous-like, pedunculated, or flat; and (2) those occurring in children, which tend to recur after removal, are usually numerous, and resemble warts. The inflammatory lesions are ordinarily attached to the vocal cords, present a globular, smooth, reddish or pale, and ofttimes pedunculated appearance.

CARCINOMA

The diagnosis of carcinoma is not difficult provided the disease is suspected; and any chronic dysphonia should arouse suspicion. Carcinoma most often affects the anterior half of the larynx and usually originates on the vocal cords, but may be found in any portion of the larynx. Lesions in the anterior portion of the larynx produce hoarseness early in the course of the disease by interfering with approximation of the vocal cords, while hoarseness may be a relatively late symptom in lesions involving the epiglottis and posterior portion of the larynx. Hoarseness occurs early in carcinoma of the vocal cord and is persistent, becoming progressively worst. In laryngeal malignancy, aphonia and pain are late symptoms. Mirror examination frequently reveals an uneven cord with a rough, nodular surface or an infiltrating lesion with fixation of the involved vocal cord. Vocal cord cancer may extend above the surface or beneath the mucosa, spread to the opposite cord and ultimately extend outside the larynx, eroding the cartilages and obstructing both the air and food passageways. Malignant laryngeal neoplasms by extension endanger the adjacent vital structures, metastasizing first to the cervical lymph nodes. At times, primary involvement of the subglottic area, ventricular bands, and ventricle is observed. Carcinoma of the subglottic area tends to spread and metastasize rapidly, rendering a less favorable prognosis than in other types of intrinsic laryngeal cancer. Malignant lesions of the epiglottis, arytenoids, aryepiglottic folds and posterior portion of the larynx are not uncommon.

Early diagnosis has not been a salient factor in successful surgical treatment, because many cases are too far advanced to be treated surgically when first examined. A high proportion of cures is obtained in laryngeal carcinoma, as compared with malignancies elsewhere in the body, due chiefly to the anatomic construction of the larynx (enclosure in a cartilaginous box), and the poor lymphatic drainage, both of which contribute to relatively late metastasis. Surgery yields the greatest number of five year cures of any method of treatment. In early malignancies of small extent and limited to a freely movable vocal cord, removal of the growth by laryngofissure is the prevailing operative procedure. By early diagnosis these lesions are discovered while the growth can still be adequately removed and the voice-box retained. In more advanced diseases, total laryngectomy is needed, and the resulting loss of the voice should be a secondary consideration. Most laryngectomized patients, however, develop a satisfactory esophageal voice and can carry on their occupations.

TUBERCULOSIS AND SYPHILIS

Tuberculosis and syphilis are always diagnostic possibilities in chronic hoarseness, and the laryngeal appearance may be confused with carcinoma. Routine serologic examinations and roentgen studies of the chest are helpful in any laryngeal disorder. Always remember that carcinoma may coexist with syphilis or tuberculosis. In general, carcinoma affects the anterior portion of the larynx, tuberculosis is found in the posterior larynx, and syphilis affects parts other than the vocal cords. This grouping is not reliable and is only suggestive. Irrespective of the location or appearance of a lesion, histologic corroboration is the essential factor in differentiating these chronic diseases.

Laryngeal tuberculosis is secondary to pulmonary tuberculosis, but the first symptom of the general disease may be hoarseness. Tuberculosis of the larynx develops slowly and often produces pain, either localized to the laryngeal area or referred to adjacent structures, frequently to the ear. Attention has been called to the pale larynx of tuberculosis, but edema and redness limited to the arytenoids, interarytenoid area, or epiglottis have been observed. When the vocal cords are involved, tuberculosis produces thickening of the cords with some superficial ulceration. In the interarytenoid area, rarely involved primarily in cancer, papillary hypertrophy and swelling over the arytenoid cartilages are often seen.

Syphilitic lesions of the larynx are not common, and in the presence of a positive serologic test the diagnosis can only be made by exclusion. In laryngeal disorders a positive serologic reaction does not necessarily mean that the laryngeal lesion is due to syphilis. Before a diagnosis of laryngeal syphilis is made, roentgen study of the chest, sputum examinations for tubercle bacilli, and a biopsy should be obtained. Luetic lesions customarily give rise to an intensely reddened larynx with marked hyperplasia and occasionally ulcerations. These lesions are rarely sharply localized, but are diffuse throughout the larynx. The iodides when used in laryngeal syphilis must be administered with great caution, for by increasing and enhancing the edema, acute obstruction may develop.

CHRONIC LARYNGITIS

The diagnosis of chronic laryngitis is made after all other possibilities have been eliminated. It develops following repeated acute attacks of laryngitis, chronic sinus disease, exposure to irritants as smoke and dust, or misuse of the voice. The voice becomes weak and hoarse, especially in the early part of the day, but improvement is noticed as the day progresses. Speaking is poorly tolerated and sensation of dryness, stickiness and burning are present. Hyperemia and hyperplasia of laryngeal tissues frequently occur, and the vocal cords become thick, irregular, dull, and, because of submucous proliferations, elevations are produced at various points. In one form, the epithelial hyperplasia appears as small local nodules on the free margins of the vocal cords, which are designated as vocal or "singer's" nodules. Hyperplasia of the entire membranous cord is found at times, giving rise to thick, edematous, polypoid vocal cords. Cupped forceps are particularly useful in removing either the small localized nodules or stripping the entire membranous cord under direct vision.

KERATOSIS

Leukoplakia or keratosis may be a precursor of carcinoma, and microscopic examination of tissue from the lesion affords the only means of distinguishing malignant from benign change. Keratosis commonly is manifested by a diffuse gray thickening with superficial ulceration overlying a portion of one or both vocal cords, and sometimes the whole lesion can be removed with one bite of the cutting forceps. If malignancy exists, even though the entire involved area seems completely removed histologically, the operation of laryngofissure should be considered.

LARYNGEAL PARALYSIS

Paralysis of the larynx arises from peripheral or central lesions involving the vagus nerve or its laryngeal branches in its course intracranially or in the neck. Central lesions affecting the vagal nuclei are not common, but recurrent nerve paralysis is observed in some bulbar lesions, as poliomyelitis. Paralysis of central origin usually is associated with paralysis of other cranial nerves, especially the ninth and eleventh. In the usual form of recurrent nerve paralysis, the abductor type with the vocal cord fixed in the mid-line, when unilateral, the voice may sound normal; but if bilateral, breathlessness becomes the chief difficulty.

The most frequent cause of paralysis is malignancy, from primary involvement of the thyroid gland, trachea, bronchi, and esophagus or metastatic lesions of the mediastinal and cervical lymph glands. Injury to the recurrent laryngeal nerve in thyroid surgery and aneurysm of the aortic arch are responsible for most of the remaining cases. Benign thyroid enlargement seldom produces recurrent paralysis. If preoperative examination of the larynx reveals paralysis, even though there are no other suggestive features, malignancy should be suspected. In trauma produced by thyroid surgery, one or both recurrent nerves may be injured. The vagus nerve may be affected in carcinoma of the esophagus, trachea or bronchi. Mediastinal enlargements, due to metastatic lymph nodes, Hodgkins disease, tuberculosis, or inflammatory lesions, may induce vagal irritation or paralysis. In wounds of the neck, either stabbing or gun-shot, and neck operations, such as diverticulectomy, the recurrent nerve may be damaged. Enlargement of the left auricle, pericardial effusion and extension from the upper lobe of the lung in tuberculosis are rare causes for recurrent nerve paralysis.

SUMMARY

Hoarseness is a symptom of disturbed laryngeal function requiring prompt investigation, the first step of which is visualization of the entire larynx. The larynx may be involved by tumors, either benign or malignant, tuberculosis, syphilis, acute and chronic infections, congenital lesions, keratosis, or injuries. Hoarseness, likewise, may be a manifestation of a general disease, which has affected the vagus nerve in some portion of its course, producing paralysis of a vocal cord. Injury to the recurrent nerve during thyroidectomy, toxic neuritis, blood dyscrasias and allergic upsets are other causes of hoarseness. Hoarseness is usually the first symptom of carcinoma, and the diagnosis of chronic laryngitis or other less serious afflictions should be made only after all grave causes have been eliminated. In addition to laryngeal examination, serologic studies, and roentgenologic studies, particularly of the chest, are necessary to render a correct diagnosis in many instances.

255 So. 17th Street

ROENTGEN THERAPY OF PNEUMONIA

Roentgen therapy, twenty-four hours after onset of symptoms of virus pneumonia in cats, reduced the duration of acute illness from 10 to 5 days. Forty-eight hours after initial symptoms roentgen therapy had little effect, state Dr. G. J. Baylin and associates of Duke University, Durham, N. C. In mice inoculated with swine influenza, roentgen therapy, forty-eight hours before infection, reduced mortality about one-third; similar therapy, twenty-four hours after inoculation, did not affect mortality.—Am. J. Roentgenol., 55:473.

BACKGROUND OF THE CANCER CONTROL PROGRAM *

Joseph H. Kler, M.D., New Brunswick, N. J.

In 1938, the New Jersey Health and Welfare Conference began its exhaustive study of every phase of health and general welfare in this state. First, all existing information was collected, assembled and coordinated to avoid duplication. Appropriate subcommittees were appointed and labored diligently. On December 21, 1939, the Conference presented a complete report to the Governor.

The Committee on Cancer made a meticulous analysis of the situation in New Jersey, as it existed in 1938 and 1939. It was found that though facilities for cancer control were well developed, they were not well organized or coordinated. For instance, New Jersey then had 83 general hospitals. Of these, 21 had cancer clinics, and 30 had equipment for deep x-ray therapy. Sixteen hospitals had varying amounts of radium available, to an aggregate of about 3500 milligrams. Twenty-eight physicians owned among themselves almost 3000 milligrams of radium. Throughout the state, in various private offices, there were then 62 low voltage x-ray therapy units and 39 high-voltage machines.

These and the various other hospital and diagnostic services were reviewed and a plan for action evolved. The committee felt that in any effective cancer control program, the private practitioner would have to be the key man. The small tumor clinic, it was agreed, would be the corner-stone of the structure that should include available tissue diagnostic service and some official state agency to aid in the coordination of the program. Adequate provision for the care of incurable cases had to be developed and a well-balanced program of professional and lay education was essential for the completeness and success of the program. The recommendations were:

1. Development of smaller tumor clinics in connection with general hospitals.
2. Statewide tissue diagnostic service for private practitioners.
3. Expansion of the activities of the State Department of Health to aid in the development of diagnostic and therapeutic facilities in existing hospitals, in cancer education and in statistical research.
4. A central research clinic primarily for clinical and fundamental research and for the diagnosis and treatment of difficult cases.
5. Agreement that relief and public assistance programs be made sufficiently broad in their provision for medical relief to assist in case finding and effective treatment of curable cancer; and that county welfare programs include provision for appropriate care of terminal cases.
6. A program for the care of incurables as a part of a general program for the care of the chronically ill.

With the passing of years conditions change. However, the program outlined above served as a guide. The emergencies of the war slowed our tempo, but we have made real progress—during the past year especially. The concern about the health and welfare of the people of New Jersey expressed by former Governor Moore has not varied in the minds of all those interested in these activities and the high ideals of the participants in the New Jersey Health and Welfare Conference have been maintained in the development of cancer control activities.

Since the termination of the war the three major groups interested in cancer control in New Jersey have addressed themselves to their tasks. The medical profession has responded well. The New Jersey Division of the American Cancer Society has done a marvelous job and the State Department of Health has organized its forces. The Cancer Control Committee of The Medical Society of New Jersey, under the vigorous leadership of Dr. Wuester, has acted as the coordinating group. New Jersey is fortunate in having Mr. George Stringfellow at the head of its division of the American Cancer Society. His philosophy is best illustrated by the following remarks:

"Laymen are charged with the responsibility for raising and administering the funds of the American Cancer Society and the medical profession has the responsibility of deciding how funds shall be spent. I cannot too strongly stress the importance of the medical profession in the cancer control program. Control of cancer is, first of all, based

* Delivered by invitation, at the Middle Atlantic States Regional Conference on Medical Service, Philadephia, May 23, 1947.

upon medical practice and the medical profession's importance in the program is fully recognized. In conjunction with the medical profession, success of the program depends upon the interest of related professions, local health and welfare organizations and the general public. Through the cooperation of all groups the cancer control program will be successful."

The New Jersey Division of the American Cancer Society has done a fine job of education, promotion and fund-raising which has made the work of the medical profession possible in the development of the cancer control program for the state as a whole.

The cancer control committee of The Medical Society of New Jersey has developed the professional side of the program on the premise that the family physician will continue to see more early cancer than all specialists combined. The practicing physician must be the front line of defense and he has been made so in the New Jersey Program. The program as developed to date is as follows:

1. The development of cancer clinics in all hospitals is urged. The physicians must decide which type will best meet the community needs—whether it be a Class A clinic with full time staff operating on a 6-day a week basis or a Class B clinic operating on a one day a week basis, or a Class C clinic operating primarily as a diagnostic clinic.

The American Cancer Society has given financial as well as technical assistance in the development of these facilities during the past year and will continue to do so.

2. Establishment of a biopsy service for practitioners through the cooperation of the New Jersey Society of Clinical Pathologists. The Cancer Society has provided biopsy containers and physicians send specimens to pathologists of their choice who examine tissues of patients who can pay fees at regularly set fees and examine tissues of medically-indigent patients gratis. To date 3700 New Jersey physicians have availed themselves of this service.

3. The development of thorough health examinations in the practitioner's office on an appointment and a definite fee basis. To date, 2000 New Jersey physicians have pledged themselves to do these thorough health examinations on an appointment basis so that the physician's office will in effect be a diagnostic center. This is exactly what it should be. The so-called cancer screening clinic has no place in a well-organized cancer control program in a state. Cancer is not limited to one part of the body and it is folly to waste time, effort and money on the development of screening clinics. We will control cancer effectively only when every physician thinks of the possibility of cancer every time he examines or treats every patient for any condition. This is the role of the family physician and his work must be made easier by supplying information to him and biopsy aids and above all, encouragement. The large screening clinics do have value of a research nature in giving us information as to incidence of various types of cancers and related information. This work should be subsidized and encouraged in selected centers. The Medical Society of New Jersey approves the development of diagnostic clinics but does not approve the use of funds of the American Cancer Society in subsidizing the operation of these clinics. It may seem like a technical distinction but it is in keeping with the philosophy and the ideals of the medical profession of the state.

4. The establishment of a tumor registry in the State Department of Health.

5. The encouragement of medical care plans on the county level for all cancer patients utilizing facilities of the general hospitals in the active treatment, nursing homes and convalescent homes and visiting nurses' assistance in the after care of such patients.

6. Some progress has been made in developing programs for the care of all chronically ill on county levels.

7. Cancer education of the public through the American Cancer Society and of the profession through articles in the Medical Society Journal written by the Cancer Committee.

This program is still in the process of development. It is patterned after the principles set forth by the New Jersey Health and Welfare Conference. It has the enthusiastic support of the physicians of New Jersey. So long as the physicians meet their obligations we need not fear for I am sure this program will succeed. Cancer is an expensive disease to treat, but the public will support so worthy a cause. New Jersey residents have demonstrated determination to do their part by their donations to the fund drives of the American Cancer Society. Now they depend upon us as the professional experts to lead the way. We must have the knowledge and the courage to do a good job and the public will give us the tools to work with.

151 Livingston Avenue

STATE ACTIVITIES

WELFARE COMMITTEE

Meeting of the Welfare Committee, 2 p. m., Sunday, December 14, 1947, State Society Headquarters, Trenton, Dr. Vincent P. Butler, Chairman, presiding.

ATTENDANCE:

Dr. Vincent P. Butler, Chairman
Dr. Royal A. Schaaf
Dr. Earl L. Wood

Dr. David B. Allman, Atlantic County
Dr. Edward Guion

Dr. H. Wesley Jack, Camden County

Dr. Charles Cunningham, Jr., Cumberland Co.

Dr. Marcus H. Greifinger, Essex County
Dr. Harrold A. Murray
Dr. Thomas W. Harvey

Dr. Wendell J. Burkett, Gloucester County

Dr. Berthold S. Pollak, Hudson County
Dr. Hugh H. Tyndall

Dr. Philip W. Baker, Hunterdon County
Dr. Barclay S. Fuhrmann

Dr. Samuel Blaugrund, Mercer County
Dr. L. Samuel Sica
Dr. John L. Wikoff

Dr. Ralph J. Faulkingham, Middlesex Co.

Dr. C. Byron Blaisdell, Monmouth County
Dr. Stanley Nichols

Dr. George B. Emory, Jr., Morris County

Dr. Morris Joseph, Passaic County

Dr. Herschel S. Murphy, Union County
Dr. Thomas J. Walsh

Dr. Ralph M. L. Buchanan, Warren County

CONSULTANTS:

Dr. Frederic J. Quigley
Mr. John J. Debus
Dr. Emil Frankel
Mr. William H. MacDonald
Mr. James E. Bryan

GUESTS:

Miss Grace Anderson, R.N.
Dr. J. L. Voss
Miss Louise Rogers
Miss Lula P. Dilworth
Dr. E. P. Duffy, Jr.
Dr. Anthony J. Conty
Dr. William F. Costello
Dr. Jerome G. Kaufman
Dr. W. James Marquis
Dr. Asher Yaguda
Mr. Vincent J. Gorman
Dr. Bror S. Troedsson
Dr. H. E. Reading
Mrs. L. Mancusi-Ungaro
Dr. Daniel Bergsma
Mrs. Asher Yaguda
Mrs. O. R. Carlander
Mrs. C. Chester Chianese
Dr. C. Chester Chianese
Dr. Carl E. Weigele
Dr. Margaret M. Wurts
Dr. Elizabeth R. Brackett

MEDICAL-SURGICAL PLAN OF NEW JERSEY
Dr. Norman M. Scott, Medical Director

It has been customary for Medical-Surgical Plan and Medical Service Administration to report to the Welfare Committee once during each year. Our figures for November were not available in time to include them on charts; therefore we decided not to report at this meeting but I am very glad to take advantage of the time allotted to me to speak informally about the voluntary medical plan movement.

It is difficult in discussing the medical care distribution problem to limit one's remarks to New Jersey. It is a national movement. At present there are sixty plans, each similar to Medical-Surgical Plan, and each organized by a unit of organized medicine, in operation. The total enrollment of these plans as of June 30, 1947, was 6,700,000 persons and it has now passed 7 million. We are now getting into big business and in addition are faced with the possible problem of taking over at least part of the functions set forth in such bills as the Taft Bill. Looking forward to this possibility, steps are now being taken to merge the facilities and efforts of voluntary hospital plans and voluntary medical plans on a national level.

On a local level, Medical-Surgical Plan of New Jersey has a current enrollment of 140,000 persons. This is not as large as we would like to have it. We have purposely expanded slowly in order to develop satisfactory administrative procedures and to test the financial structure of the Plan and the attitude of physicians. After five years of experience we

are satisfied that we are on the right road. The Plan is financially sound, is entirely self supporting, has paid all eligible claims in accordance with its schedule of benefits, received satisfactory cooperation from the profession and hopes to expand more rapidly in the future.

As the Plan expands we too get into big business. Our current income is at the rate of more than a million dollars a year. The administrative methods designed to meet the needs of the early days of the Plan are no longer applicable and in redesigning these procedures we will evolve a closer merging with Hospital Service Plan of New Jersey, at the same time maintaining our autonomy, control of payments to physicians, and matters relating to patient physician relationship and the relationship of physicians with the Plan.

The earned subscription income of the Plan for the 11 months ending November 30, 1947, was $847,182 of which $607,343 was paid to physicians for eligible care rendered our subscribers; $98,022 was placed in reserve. The administrative cost was 17 per cent of earned income. The total earned reserve of the Plan is $270,000. The earned income for November 1947, was $90,636.

Medical-Surgical Plan of New Jersey is designed to operate within the framework of our present methods of practice, in observance of the ethics and expressed policies and traditions of the profession. Its success depends upon the integrity and sincerity of the profession in carrying out the provisions of its subscription contract. If the integrity and ethics of the profession do not stand up to this test the Plan will not be successful. On a national basis three types of adverse criticism are leveled at the profession in carrying out the provisions of voluntary medical care plan contracts. I have every reason to believe that these criticisms are not applicable to any great extent in New Jersey. These criticisms are:

1. That participating physicians find ways of contravening the provisions of the contracts relative to accepting as complete payment the amounts paid by the plans for eligible services rendered persons with incomes below the levels specified in the contracts. This is not prevalent in New Jersey. To date, in every such case reported to us, the physician has always very willingly refunded such money to the subscriber when the matter was explained to him. This indicates high integrity among New Jersey physicians and has a very favorable effect upon industrial employers whose support is so essential to the success of the voluntary plan movement.

2. That some participating physicians practice in accordance with a unilateral fee schedule, charging each patient the same amount for a given service regardless of the patient's income, and inform the low income people that if they cannot pay the regular fee they are at liberty to accept free care as a clinic case. Such action, if prevalent, would be fatal. These low income people do not want free medical care. They want medical care at a cost they can afford to pay. They want to maintain their financial independence and their self respect. Medical-Surgical Plan is designed to provide this. If the medical profession or individual physicians are not willing to accept and fulfill this philosophy they are simply promoting the cause of compulsory sickness insurance. I do not think such practice is prevalent in New Jersey, only one such case having been reported to us among about 25,000 cases.

3. That regarding patients whose incomes are a few dollars above the ceilings set forth in the contracts, some physicians insist upon payment of their regular fee or in some instances their regular fee plus the benefit paid by the Plan, thus invalidating the contract. Such actions on the part of physicians are just plain dishonest and unethical. Participating physicians must adjust their fees to the ability of the subscriber to pay and must give full and honest credit for the amount payable by the Plan. We have no way of knowing how prevalent this practice is in New Jersey. No such specific case has ever been referred to us. We hope, and believe, that it does not exist.

All in all the cooperation of the profession in New Jersey has been excellent. We receive a very minimum of complaints and I do not believe the criticisms I have outlined are applicable in New Jersey.

The main effort of Medical Service Administration is the operation of the Newark City Plan for care of the indigent and medically indigent. This plan continues to operate to the complete satisfaction of the City authorities, the patients and physicians. We believe it represents the ideal solution for this problem. It is not the policy of Medical Service Administration to promote the expansion of such a plan over the heads of County Medical Societies. If any County Medical Society sees an opportunity to improve the medical care of the indigent or medically indigent in any of its communities by a plan similar to the Newark Plan, and in accordance with the principles approved by the House of Delegates at its 1947 session, Medical Service Administration will be glad to lend its efforts to the establishment of such a plan.

SUBCOMMITTEE ON LEGISLATION

Dr. B. S. Pollak, Chairman

1. Preventatives to Undesirable Legislation

A dinner conference was held last month (November) by the legislative keymen of three southern counties of the state and county officers, with the Congressman of their district. This conference served to point up and underline several things which engaged the attention of this Committee at this morning's meeting and, which, in our opinion, are deserving of consideration by the Welfare Committee.

It was made clear to the Congressman at the beginning of the conference just mentioned that its purpose was to afford an opportunity for the representatives of the three counties present to discuss some pending bills before Congress of major importance to public health and to the medical profession, and to present the point of view of organized medicine of the State with respect to these measures and the reasons for its attitude.

The first measure referred to in the discussion was the Wagner-Murray-Dingell Bill (S-1320). Immediately upon mentioning this measure the Congressman remarked "I am opposed to this bill, *but I do not think mere opposition to it is the answer*". It was agreed, of course, the observation of the Congressman, that mere opposition to the Wagner Bill was not the answer, was entirely correct. There then followed a discussion of the measures that were in operation in New Jersey, sponsored by our Society, to meet the needs for improved distribution of medical care services. This legislator displayed keen interest in the Medical-Surgical Plan and in the "City of Newark Plan", neither of which, he stated, he had ever heard of previously. He asked many questions about both plans and inquired whether the Newark City Plan could be adapted to other communities of the State. He was assured the principles of the plan could be applied to any community.

One other observation this Congressman made at the conference is, we think, deserving of attention. Following discussion of the present social trend, he remarked that he "didn't believe this trend could be reversed". He did agree, however, that some of the trend might be diverted into more worthwhile channels and that other proposals, in his opinion, could be prevented by the adoption of suitable measures (preventive).

The Legislative Committee in previous reports has stated its view that the results of its legislative endeavors are dependent, in no small degree, upon the activity or non-activity of other agencies of the Society.

We believe that the profession generally is aware of the fact that our Society has, in its Medical-Surgical Plan, one of the very soundest medical service plans in operation in the United States. It is appreciative of the fact, we feel sure, that the members of the Society who are members of its Board of Trustees have contributed greatly to the soundness of the present position of the Plan. And we know too that the capable administration by Dr. Scott, Medical Director of the Plan, has been responsible, in no small degree, for its success. The point we wish to make here is that this Plan has now been in operation over five years. We understand it has approximately 140,000 beneficiaries. This represents not more than 3 per cent of the population of the State. In view of this, we doubt that it will be possible much longer to maintain that we have an effective plan operating in this State to cover employed workers and their families. As a preventive measure to legislation whose effect would be to further extend State control of medicine, it is our opinion that steps should promptly be taken to more rapidly enlarge the membership of the Plan.

The "City of Newark Plan" is providing at-home care for the indigent and medically indigent in a manner mutually satisfactory to the administrative authorities of Newark, to its relief clients and to the doctors of Newark. The principles of this plan have proven to be sound and workable. Should not the Society be making continued efforts to place this plan in operation in other communities of the State? Here again we are thinking in terms of preventatives to undesirable legislation.

2. Amending Senate Bill No. 545

Hearings on S-545 — the Taft-Smith-Ball-Donnell Bill—are scheduled to resume after the convening of the 1948 session of Congress. In our opinion, the present philosophy of Title VII of this Act, providing grants-in-aid to *all* states for the purpose of providing improved medical care services and hospital care for "families and individuals with low income" is not in accord with the Platform of the American Medical Association, Paragraph D, and, in the light of present trends in social thinking, may well be the precursor of compulsory sickness insurance. Admittedly, this is not the intent or purpose of the measure. This bill was introduced by its sponsors as an antidote to the Wagner-Murray Bill to avert federal control of medicine and to make possible the formulation by each state of plans designed by the individual states for improving medical care services and hospital care for per-

sons of low income. The individual states and their sub-divisions, under *the present* provisions of the measure, will determine who are to be the beneficiaries of the Act.

It is impossible, in a report of this nature, to discuss at length the implications of Title VII of this bill, but

(1) In our opinion its philosophy is not in accord with the principles of the Platform of the A.M.A. (Paragraph D).

(2) It is not in accord with the position taken by The Medical Society of New Jersey.

(3) If grants-in-aid are to be made to all states and not confined solely to the states (apparently eleven or twelve in the South and Southwest) which probably *can demonstrate need* of federal financial assistance, a universal system of federal control will have been inaugurated in the practice of medicine, which, by subsequent acts of Congress, may be tightened and rapidly extended so as to apply to the entire population of the country. Thus, there might be attained the full objective of the Wagner-Murray Bill: compulsory sickness insurance.

In view of the fact that further hearings are to be held on this bill, it is recommended that the Welfare Committee request the Board of Trustees to give consideration to the advisability of instructing the Delegates of this Society to formulate and introduce resolutions at the interim meeting of the House of Delegates of the A.M.A. early next January, designed to amend S-545, the Taft-Smith-Ball-Donnell Bill, so as to make grants-in-aid *applicable only to those states which can demonstrate need of federal financial assistance* to carry out the purpose of Title VII.

3. *Consolidation of Professional Boards*

In the report of the Subcommittee on Legislation, September 14, 1947, brief reference was made to the provisions of the new State Constitution which will make necessary the consolidation of the various professional licensing boards into one of the presently existing departments or into a new department to be created by the Legislature.

It will be recalled that three years ago there was a serious threat made to accomplish this purpose—now made mandatory by the provisions of the Constitution. This subject at that time engaged the serious consideration of the allied medical professions: medicine, dentistry, pharmacy and nursing; and later, also the optometrists and veterinarians. The Commission on Reorganization of State Departments at that time was inclined to recommend placing the various allied professional boards in the Department of Health. Representatives of all the professions were opposed to this proposal. It was the feeling at the time that if the boards had to be placed in one of the existing departments, the preferable place would be the Department of Education, but, after further consideration, it was agreed that the most desirable solution would be to establish a Department of Professional Boards, organized in such a manner as to interfere as little as possible with the present autonomy of the various boards.

Two meetings of representatives of professional societies and of corresponding licensing boards were held last month. At the first meeting, only representatives of medicine, dentistry, pharmacy and nursing attended. After re-canvassing the situation, all agreed that it was desirable, if possible, to have established a Department of Professional Boards. At the second meeting, besides the representatives of the allied medical professions, representatives of optometry, veterinary medicine, accounting, engineering and land surveying, and architects attended. The representatives of these other groups also agreed that the most desirable solution of the problem was the creation of a Department of Professional Boards.

An executive committee of the enlarged group was appointed at the latter meeting, consisting of one representative from each of the professions, which was empowered to formulate a letter and a brief to be sent to the Governor, outlining the reasons of this group for proposing the creating of a new Department of Professional Boards.

Both the Senate and the Assembly have already appointed Committees on Reorganization of State Departments. These Committees are to confer with the Commission on Reorganization of State Departments, and it is expected that bills will be introduced during this coming session of the State Legislature, to accomplish the purpose of consolidation.

It is to be presumed that President Schaaf in his remarks at today's meeting of the Welfare Committee will speak of the conference that he, accompanied by the Executive Secretary of this Committee, held with Governor Driscoll this past Thursday (December 11). However, for completion of the Legislative Committee report, brief reference to the conference is included.

Its purposes were (a) to enlist the Governor's support, if possible, of the Society's position with respect to the Taft-Smith-Ball-Donnell Bill (S-545), and (b) to discuss the matter of consolidation of professional boards, and especially the proposal set forth in the letter and brief (previously referred to in this

report) to create a Department of Professional Boards.

We found the Governor in complete accord with the Society's views as to S. 545. He is opposed to the indiscriminate application of grants-in-aid to the states. He realized thoroughly the increasing amount of federal control involved in such legislation and is opposed to it. He agreed to the danger of further federal control of medicine inherent in S. 545, which we have endeavored to point out in topic No. 1 of this report.

Discussion of the proposal to create a Department of Professional Boards received the close attention to the Governor. While there was nothing to indicate what the Governor's ultimate reaction may be to this proposal, at any rate it may be said that it was sympathetically received. At the Governor's suggestion and by his arrangement we were afforded an opportunity, immediately after the conclusion of our conference with him, to present this proposal to the Commission on Reorganization of State Departments, which was meeting at the time in the State House.

It seemed to us that the Commission was not antagonistic, at least initially, to the proposal made. Its members asked a number of questions, especially as to detailed functioning of the Board of Medical Examiners. President Schaaf, being a member of the Board, was able to give complete answers to these questions.

Neither the Governor nor the Commission on Reorganization appears to be set upon the proposition of doing away with the dedicated funds of the boards. Our impression was quite to the contrary.

We spent a half hour with the Governor and approximately the same length of time with the Commission. We are of the opinion that both of these conferences were very timely. We came away from them considerably heartened; our hope is that future events may justify the present feeling of encouragement.

4. County Legislative Machinery

At this morning's meeting attention was given to the matter of improving legislative setups within the counties and steps will be suggested to county society keymen and officers in the near future which, it is hoped, will be helpful toward accomplishing this purpose.

Discussion

Dr. Schaaf reported on the conference he and Dr. Quigley had attended with the Governor and the Special Commission on Reorganization of State Departments. The Governor was most cordial and agreed with our viewpoint. He is vigorously opposed to the principle of grants-in-aid.

The Commission had given no thought as to where the various professional boards should be placed. They listened attentively and interestedly to our proposal of a special department in which all boards, with the exception of morticians, beauticians and barbers, should be placed. It is our feeling that these boards belong in the Department of Health.

The Governor has not yet reached a decision regarding the dedicated funds of the various boards, but the Commission has not yet decided to abandon them. We presented cogent reasons why the dedicated funds policy should be continued.

Dr. Scott expressed his desire to transmit known facts before the Legislative Committee recommends more rapid expansion of the Medical-Surgical Plan.

He stated to expand too rapidly is dangerous. Because of pressure, California expanded too rapidly and they are now paying 80 per cent of their schedule and are not financially sound. The Massachusetts Plan expanded from 180,000 to 700,000 in two years, at the same time trying to increase the scope of their benefits. I was told yesterday that they hope to break even this year. As a result, they will have to revamp their contract and eliminate laboratory work and x-ray services. When you have to revamp your contract and remove benefits, the resulting public relations are bad.

As far as the City of Newark Plan is concerned, we would be glad to place this in operation in any community. There is one defect in this plan, however. Under the state law, care of the indigent and expenditure of public money for their care is a matter of municipal responsibility, therefore municipalities must contribute. In a small community this type of plan is almost impossible to operate. We should change our law and place relief on a county basis. Promotion of the Plan in communities is a function of the county medical societies. If a county society has, within its area, a community in which the medical care of the indigent is not satisfactory, it is the responsibility of the county society to make recommendations, and we will be glad to apply the plan to any community large enough to make it worthwhile.

We have the fair promise of taking over the dependent children problem in this state, which is a group composed of about 140,000 children. We have been approached by the Department of Institutions and Agencies regarding this,

and it will go before the Board of Trustees in January. I hope we can get this started; if we do we probably will have volume enough to make Medical Service Administration self-supporting. The Newark Plan is not self-supporting, we must have greater volume to make it so.

Upon motion, seconded and carried, the report of the Legislative Committee was approved.

MEDICAL PRACTICE

Dr. Herschel S. Murphy, Chairman

The Standards to Decrease Neo-Natal Mortality, as approved by the Advisory Committee on Child Health, the Advisory Committee on Maternal Welfare and the Subcommittee on Public Health at previous meetings, were amended by the Subcommittee on Medical Practice and approved. The amendments were also approved by the Chairmen of the other three Committees mentioned.

Standards to Decrease Neo-Natal Mortality

In order to establish better care for the infant in hospitals, it was recommended that the standards outlined below be followed by hospitals as soon as can be readily accomplished:

1. In order to stimulate the breast feeding of newborn infants, it is recommended that no prelacteal feedings be given until the necessity for artificial feeding is established.

   a. Undue attention is paid to loss of weight in newborn infants. Weight loss of 10 per cent of initial weight is considered physiological.

   b. Water of 5 per cent glucose solution be given after nursing.

2. In the case of the mothers who must be discharged from the hospital on the fifth to the seventh day after delivery, the mothers should be warned to get sufficient rest upon going home to insure continuation of breast feeding.

3. The general rules and policies for the conduct of the nursery should be made by the attending pediatrician, attending obstetrician and medical board.

   a. These rules and policies should be observed by all the hospitals in New Jersey until changed or modified.

   b. Maintenance of adequate charts on newborn infants is essential. Pertinent notes on all newborn infants should contain accurate notations about general behavior, cyanosis, palsies, feeding, vomitus, stools and the condition of the skin. All birth weights must be recorded and should be on newborn death certificates.

4. It is advisable that all premature infants should be under supervision of a recognized pediatrician or pediatric service within 24 hours after delivery and when a premature birth is expected facilities should be present for special care and resuscitation.

   a. It is suggested that a birth weight of 5½ lbs. or less be taken as the criterion of prematurity.

5. When undertaking new construction or remodeling of nurseries, the Hospital Standards of the Department of Institutions and Agencies of New Jersey should be consulted for guidance.

6. A portion of a general staff meeting in each hospital shall be annually devoted to the importance of breast feeding and the record of fetal mortality in that hospital compared to the general average.

Upon motion, seconded and carried, the Standards were approved.

Upon motion, seconded and carried, a recommendation that copies of the above Standards be sent to the superintendents of all hospitals and chiefs of staff was approved.

Amendment to Medical Practice Act

In meeting with a member of the State Board of Medical Examiners and the Deputy Assistant Attorney General in charge of legislative matters of the Board, the Chairmen of the Advisory Committees on Laboratory Medicine and Radiology discussed changes necessary in the Medical Practice Act to bring the practice of roentgenology, anesthesiology and pathology within the definition of the Act. It was reiterated that such changes would upset all the favorable rulings of the courts. The group finally decided it would be best to amend the section on who is regarded as a practitioner to include those who use any means or methods designed to be used for diagnosis or treatment.

Upon motion, seconded and carried, this section of the report was referred to the Legislative Committee for study.

Ambulatory Private Patients

The Advisory Committee on Radiology recommends, with the approval of the Subcommittee, that the sending of ambulatory private patients to hospitals for x-rays, laboratory examinations and physical therapy treatment be discouraged where facilities are available in private physicians' offices. Nothing in this recommendation shall be interpreted as interference with existing public health studies, mass x-rays or studies, or clinic care of the indigent.

Upon motion, seconded and carried, the recommendation was approved.

Telephone Listing of Specialists

The Advisory Committee on Radiology met on November 5 and discussed the listing of medical specialists in the telephone directories. It is the feeling of this Committee that such listings be made.

No action on this matter was taken by the Subcommittee as yet; the matter will be reported at the March meeting of the Welfare Committee.

Blue-Cross - Medical-Surgical Plans

The Medical Practice Committee requests an interim report from the Board of Trustees as to what action has been taken in regard to transferring the charges for all professional and medical services from the Blue Cross to the Medical-Surgical Plan.

No action was taken on this request.

National Society for Crippled Children and Adults, New Jersey Chapter

A communication from the New Jersey Chapter of the National Society for Crippled Children and Adults, outlining the formation of the New Jersey Chapter, reveals:

1. It is a duplication of existing facilities.
2. No actual need for such Chapter is shown.
3. If there is occupational therapy, it is better that it be given in the hospital from the standpoint of the public so that all may benefit.
4. If there is need for money, it should be given to the hospitals.

Through the Advisory Committee on Physical Medicine, which has investigated this Society, it is recommended that we do not approve this project as presently proposed; that further consultation be held between representatives of the New Jersey Hospital Association, The Medical Society of New Jersey, the National Society for Crippled Children and Adults, as to how a New Jersey Chapter can be set up for the best interests of the public; copy of this recommendation to be sent to the New Jersey Federation of Women's Clubs, the National Society for Crippled Children and Adults, Miss Brokaw of the New Jersey Chapter, and the New Jersey Hospital Association.

Upon motion, seconded and carried the report and recommendation were approved.

Nursing and Nursing Education

The formulation of regulations for training of practical nurses has been received with astonishment. We are particularly concerned over the fact that the Chairman of our Advisory Committee is the only representative of the Medical Society permitted to the conference at which was discussed the standards of education of practical nurses. It was the understanding that when the law was set up for the licensing and training of practical nurses that it was to be under the joint control of the Medical Society, the Hospital Association and the Nurses Association.

The Committee feels that ample representation from The Medical Society of New Jersey should attend each meeting; before standards are adopted for the training of practical nurses the Manual of Training should be approved by The Medical Society of New Jersey through its Advisory Committee on Nursing and Nursing Education, the Subcommittee on Medical Practice, the Welfare Committee and the Board of Trustees.

Discussion

Dr. Murphy quoted the following from the minutes of the Welfare Committee, January 12, 1947 (Report of the Subcommittee on Medical Practice re Nursing Practice Act Revision)—"There is one provision that we are requesting in that new act. It meets with the approval of the nurses and that is this: that instead of defining the minimum requirements for the practical nurse, which is very, very difficult to do, we substitute for that in the act the provision that agreement shall be reached by The Medical Society of New Jersey, the New Jersey Hospital Association and the New Jersey State Nurses Association as to the requirements, so that it is possible to change them without having to change the act through legislation. (Motion that the Committee be empowered to consider this further was approved.)"

From the Nursing Practice Act, Chapter 262, Public Laws of 1947, Dr. Murphy read the following—"It shall approve schools of practical nursing which shall conform to the standards, curricula, and requirements prescribed by the board, and suspend or revoke approval for violations thereof; provided, that this power shall not extend to schools operated by any board of education in this state. It *may* consult with The Medical Society of New Jersey and the New Jersey Hospital Association with respect to any matter relating to the administration of this act and *shall* consult with those associations with respect to standards and curricula and any change thereof for schools of nursing."

Dr. Murphy expressed concern over the fact that the Medical Society *may* be consulted and thought the wording was very liberal.

It was the opinion of Dr. Schaaf that it is mandatory and not optional that they shall

consult with us; that we have a legal right to demand that we be consulted; and further that we should promptly address a formal communication to the State Board of Nurses Examiners inviting their attention to this and demand that we be participants.

Dr. Quigley stated he did not think we should be quite so rigid. Some of the trouble we are encountering certainly is something for which no one could be blamed. When this matter came up some of the nurses were entirely in agreement but a large group viewed this not too pleasantly. For years they have had absolute control of the whole nursing situation. We cannot take away from the Board of Nurses Examiners the authority invested in the act. I will say as a group that my own contacts are good and they have always been cooperative.

Dr. Schaaf suggested tabling this portion of the report, Dr. Quigley to consult with counsel to determine our rights, thus ironing it out a little more amicably.

Dr. Murphy voiced objection to tabling the report and requested immediate action.

Dr. Jack, Chairman of the Advisory Committee on Nursing and Nursing Education, reported on the meeting in Newark in November at which there were six or eight nurses present, a representative of the State Department of Education, the President of the New Jersey Hospital Association and himself. His request that Dr. Zehnder, Chairman of his Committee last year, attend with him was refused. At the meeting the proposed Manual and various points of the curricula were discussed. The impression received was that the practical nurse was being rather highly trained, being made into a sub-standard of a graduate nurse rather than meeting the needs of the practical nurse.

Another meeting will be held on December 16 to discuss where and how these practical nurses should receive their training—whether in the various hospitals or in certain centers set up for that purpose.

Dr. Schaaf again suggested Dr. Quigley's contacting our counsel. Also, to get a postponement of the meeting on the 16th and have an adequate number of representatives invited to a meeting to be held when the doctors could attend.

Dr. Tyndall suggested Dr. Jack be instructed to report to the Welfare Committee, thus forcefully calling to the nurses' attention the amount of consideration being given this matter.

Upon motion, seconded and carried, this section of the Subcommittee report was approved.

Display of Degree

The Medical Practice Committee recommended to the Welfare Committee and the Legislative Committee that consideration be given to amending the Medical Practice Act so that any person licensed to practice medicine and surgery in the State of New Jersey must display only the degree under which he received his license to practice.

Dr. Schaaf stated this sounds easy and practical but anyone who has a degree of any kind is entitled to use that degree and may display it at any time or place he wishes. Such an amendment would be promptly declared unconstitutional and there is no need even to consider it.

Dr. Burkett reported this matter had been discussed several times by the State Board of Medical Examiners. Last year they were criticized when they asked their counsel to attempt to have some clarification of the status of the schools in the mid-west. This was passed to the Secretary of State and he passed it on to the Attorney General. There is absolutely nothing that you can do about it and the Board has every confidence in its counsel.

Upon motion, seconded and carried, the Welfare Committee recommended the matter be referred to the Legislative Committee.

PUBLIC HEALTH

Dr. Samuel Blaugrund, Chairman

Public Health Week—1948

It was recommended that the Medical Society name the first week of November, 1948, as "Public Health Week" and Governor Driscoll be requested to issue a proclamation for such week.

Upon motion, seconded and carried, the Welfare Committee left the decision as to the time of Public Health Week in November to the Subcommittees on Public Health and Public Relations.

New Jersey Heart Association

Dr. Blaugrund announced that the Board of Trustees at its meeting on November 16 endorsed the proposal to establish a New Jersey Chapter of the American Heart Association.

Through the Advisory Committee on Cardio-Vascular Diseases, the Public Health Committee approves the following five purposes of organization of the New Jersey Heart Association:

1. The study, dissemination and application of knowledge concerning the causes, treatment and prevention of diseases of the heart and circulation.

2. The improvement of facilities and services within the State of New Jersey for the diagnosis and treatment of such diseases.

3. Professional education of physicians, nurses, medical social workers and teachers, so that each of these groups may be in a position to accept the responsibilities involved in developing a community program.

4. Lay education for the guidance of those needing services; and, when a community program has been established, for the dissemination of information which will urge patients to seek early medical advice.

5. Public relations and fund-raising campaigns designed to publicize and support the program of the local association, and also to provide funds to be distributed on a national basis for research in cardio-vascular disease.

School Health

Through the Advisory Committee on Child Health, the Public Health Committee approved the following resolution and recommends it be presented by the New Jersey Delegates at the January meeting of the House of Delegates of the American Medical Association:

In order to improve the working relationship for Better School Health Programs among (1) school administrators, (2) school physicians, (3) nurses, (4) boards of education, and (5) interested health agencies, particularly at *local effective* levels,

Be it resolved, that The Medical Society of New Jersey requests the House of Delegates of the American Medical Association, at their January, 1948 meeting, to request or direct the Bureau of Health Education of the A.M.A. and the State and County Component Medical Societies, in cooperation with the State Departments of Education, Health and other suitable state official and non-official agencies interested in school health, to set up effective *State* and *County "Better School Health Committees"* to work for the installation of a Modern Better School Health Program in each school system or unit in the United States, operating under *permanent local* Better School Health Committees in each school system, whose minimum membership shall include the School Administrator, School Physician, School Nurse, President and Secretary of the local Board of Education, and President of the local P.-T. A., together with suitable representatives of interested health agencies.

Whooping Cough Control

The Committee recommends the endorsement in principle of the giving of booster shots to pre-school children for whooping cough control as recommended by the State Department of Health.

Tuberculosis

The following recommendations of the Advisory Committee on Tuberculosis are approved and presented for your consideration with a recommendation of approval:

1. That The Medical Society of New Jersey, in cooperation with the New Jersey Tuberculosis League, ask Drs. Doppler and Douglass, together with Mr. Bryan, to visit those counties that have no established tuberculosis facilities and recommend to their county medical society, that arrangements be made so that physicians may send their patients for chest x-ray at any time.

2. Endorsement of the following policy statement passed recently by the New Jersey Tuberculosis League: For each county there should be suitable and adequate facilities for finding cases of tuberculosis and for the diagnosis and care of patients in need of treatment. These facilities should include a modern health education program, laboratory service, x-ray and diagnostic clinics, institutions for treatment, social service and a program of rehabilitation. All these should be available to the public and to tuberculosis patients in any stage of the disease, and without regard to the capacity to pay.

Upon motion, seconded and carried, the report of the Public Health Committee was approved.

PUBLIC RELATIONS

Dr. L. Samuel Sica, Chairman

1. Hand Book for "Health Week" Programs

We have prepared a proposed "Hand Book for 'Health Week' Programs", to be distributed to County Societies to help them in planning "Health Week" observances in their principal towns and cities. This, of course, to be done in cooperation with the Committee on Public Health.

We recommend that this hand book be printed and sent to each County Society with a letter urging that a committee be authorized to plan local "Health Week" programs.

If a sufficient number of County Societies will join in this project, it is recommended that the State Society take the following steps:

1. Arrange with Governor Driscoll to proclaim the designated period as "State Health Week".

2. Arrange with the Sunday newspapers in the State to publish a special "Health Week" supplement on the Sunday on which the "Health Week" begins; feature articles on health services and facilities to be furnished by the State Medical, Dental, Nursing, Pharmaceutical and Hospital Associations, State Departments of Health, Education, Institutions and Agencies, etc.

3. Arrange with the New Jersey Health Congress to support the program and ask all its member agencies to take part in it.

4. Arrange to present an exhibit at the State Fair, with a preview of the Exhibit being placed in the State House, the P.R.R. Station in Newark, or some other strategic spot during "Health Week".

2. The New Jersey Health Congress.

The New Jersey Health Congress is showing encouraging signs of fulfilling the purpose for

which it was organized. At the very least it is providing a bi-monthly forum at which health problems are considered by representatives of the various member groups. From our own point of view, it offers perhaps the most valuable single point of contact we have with the lay groups represented.

At the last two meetings, the discussion has been well focussed, and representatives of the Farm Bureau, the State Chamber of Commerce and both Labor Organizations have taken a formal part in the proceedings. Promising contacts have been made with the State Dental Association and the Welfare Council of New Jersey, and it is expected that before long the formal organization will be complete with all of the 22 selected state-wide organizations officially represented.

We believe it is in the best interest of The Medical Society of New Jersey to treat this as a major project of our own for as long a time as we shall be responsible for its financial support and organizational functions.

Therefore, we recommend that the administrative work of the New Jersey Health Congress be authorized as a regular function of The Medical Society of New Jersey, to be carried on on regular time.

3. Membership News Letter.

It is suggested that the names of cooperating lay and official agencies as well as important lay friends of the Society be added to the mailing list of our Membership News Letter, at the discretion of the Executive Officer.

4. "Health Hints"

The following steps are recommended to bring about greater use of Health Hints.

(a) That we discontinue the use of mats prepared and distributed by the Western Newspaper Union.

(b) That we mimeograph and distribute "Health Hints" direct from this office each week.

(c) That we ask each County Society to agree to act as co-sponsors of this material within its own jurisdiction, and request the editor to insert the name of the County Medical Society in the signature note introducing each release.

(d) That the distribution of these columns in mimeographed form be authorized for school papers and for science and hygiene teachers in the schools, wherever the superintendent of schools will approve the suggestion.

5. Public Relations Program for County Societies.

It is proposed that we urge each County Society Public Relations Committee to include the following projects in its program for the coming year.

(a) Cooperation with the State Society in promoting use of "Health Hints" in local papers, as above proposed.

(b) Cooperation with the State Society in promoting use of A.M.A. radio programs, wherever a local radio station is in operation. (This work to be done, for the present, through the Woman's Auxiliary.)

(c) Cooperation with the State Society in arranging for a "Health Week" observance in 1948.

(d) Organization of a County Society Speaker's Bureau, with speech outlines and material on many subjects to be available on loan from the State Society.

(e) That each County Society select the most serious public health problem or deficiency existing in its county, and concentrate on it with a program of public education and cooperative action with other interested agencies, *under the leadership of the County Medical Society.* The State Society should be ready to furnish information and to do a certain amount of research where necessary, in helping the County Society prepare its case. We should also be ready to consult on organization and publicity methods.

As a first step in promoting better coordination between the County Societies and the State Society in our public relations program, it is proposed to hold, sometime in February, an all-day public relations conference with the County Society Presidents, Presidents-elect, and Public Relations Chairmen and Committeemen, and Public Relations Auxiliary Chairmen, at which time the above program can be discussed with these representatives. At the same time we can clarify the place of the Woman's Auxiliary in this work, and discuss the inter-relation between the legislative and public relations work.

6. Appointment of Local Representatives.

We propose to arrange for a "Public Relations Representative" of the State Society in every city having a daily newspaper or a radio station. These members would serve as liaison officers between State Society Headquarters and the publicity media in their communities. They would receive copies of all news releases being sent to their local paper, and they would be able to supply local "color" or a local interpretation for each general release from the State Society. The Local representative would also act for the State Society in all radio contacts in his area.

We recommend that the County Societies be asked to use members of the County Society Public Relations Committees.

7. Quarterly Bulletin for Lay Organizations.

We propose to send a quarterly one-page letter to lay organizations throughout the State, describing the public projects and policies of the State Society, offering spot notices

for their own bulletins. This bulletin would be sent to presidents of P.-T.A.'s, Chambers of Commerce, Health and Welfare Organizations, Women's Clubs, Labor Unions, Civic Clubs, Fraternal Organizations, Hospital Boards, etc. The mailing list is estimated at 500.

8. Review of Existing Program.

Our present program includes our Membership News Letter, radio programs, "Health Hints", news releases, contacts and communications with lay and official agencies, county society visitations, executive service for the New Jersey Health Congress, etc.

Our radio programs are now being broadcast regularly over five of the nine major outlets of the State, and we hope to make arrangements with the rest of them soon.

"Health Hints" have been regularly prepared and distributed.

The Executive Officer has visited so far eleven of the 21 county societies. In every case he has been greeted most cordially and has been given every opportunity to get acquainted. In addition, the Executive Officer has attended numerous committee meetings, in order to familiarize himself with the existing and evolving policies and services of the Society.

9. Community Health Councils.

The county units of the Woman's Auxiliary are now engaged in organizing "health councils" to put into effect our school health program.

We believe these "school health councils" should become permanent organizations. At an appropriate time, they should be converted into general health councils, by including representatives of other health agencies not already sitting with the school health council.

Each County Medical Society, we believe, should take the initiative in organizing local health councils. As a matter of fact, the A.M.A. has recently urged county societies to do just that—but for the primary purpose of promoting enrollment in voluntary health insurance plans.

Whatever program a local health council may adopt for action—and there are plenty of things for such a group to do—they offer the County Medical Society an opportunity to take and retain the leadership in public health and medical affairs.

This recommendation, if adopted, should be put into effect only when the efforts of the Woman's Auxiliaries to implement the School Health Plan have been concluded, and the work should, if possible, be continued through the Woman's Auxiliary who have been most effective in aiding and forwarding our public relations work.

Upon motion, seconded and carried, the report was approved.

The meeting was adjourned upon motion at 3:55 p. m.

THE SCHOOL PHYSICIAN AND HEALTH EDUCATION

The Medical Society of New Jersey finds itself in the enviable position of doing pioneer work on a project that is assuming national importance. The Woman's Auxiliary has been chosen to implement the splendid work done by Dr. Blaugrund of The Medical Society of New Jersey and Dr. Guthrie of the Department of Education.

No change in the goal of ideal school health standards can be made in this state without the help and the backing of the school physicians. The school physician today is one of our most valuable spearheads against compulsory medicine, for he stands in the strategic position of being able to educate the child who will be the citizen of tomorrow, as well as the parent who is the voter of today, as to what a thorough physical examination should mean.

There are many details to work out, but if school physicians know that we are laboring to further their sphere of influence and working for compensation commensurate with their years of training, I am sure that we can depend to the utmost on their cooperation and help.

All over the nation lay organizations are taking an interest in health matters and health legislation. It is our hope that these county councils developed under the leadership of the County Medical Society in the person of its president, its school health committee, and its Auxiliary representative, will become the permanent *modus agendi* for local health matters, and that in this small way we, as an Auxiliary, shall have done our bit to maintain for our husbands the role of community leadership accorded our grandfathers by the citizens of their day.

FRANCES MANCUSI-UNGARO, President
Woman's Auxiliary to The Medical
Society of New Jersey.

PROPOSED AMENDMENT TO THE CONSTITUTION

The following proposed amendment to the Constitution was approved by the House of Delegates at the 1947 Annual Meeting and will be presented for final approval at the meeting in April, 1948. The proposed addition of Section 7 to Article IV of the Constitution is herewith published in full in compliance with the constitutional provision to that effect.

SECTION 7—*Emeritus Membership*

The emeritus membership group shall include physicians who have been members in good standing of a component county society for at least twenty years, and who, by reason of age or infirmity, have retired from the active practice of medicine, or members of the Society who have been disabled by reason of military service. They shall have all the privileges of membership, but their respective component societies shall not be assessed for such members, provided they are carried as emeritus members in their component societies. The emeritus members shall not be included in the membership of a component county society when computing the number of delegates to which such society is entitled.

NAVAL RESERVE MEDICAL DIVISIONS TO ORGANIZE

Fourth Naval District Headquarters at the Philadelphia Naval Base announces that twenty-two Volunteer Naval Reserve Medical Divisions will be organized within the Fourth Naval District. These divisions will be established at medical centers and educational institutions under the direction of an inactive reserve medical officer. In the event of a national emergency, these divisions will serve as personnel pools and may be ordered to active duty individually or in teams for assignment to naval hospitals, naval bases or overseas duty.

A medical division comprises seventy-five reserve medical officers and fifteen specialists in allied sciences, fifty naval nurses and two hundred and fifty reserve hospital corpsmen. Commander of the Naval Reserve Division for Southern New Jersey is Captain W. A. Crist of Camden.

Naval Reserve Medical Corps personnel who wish to participate or desire further information, should write to the Commandant, Fourth Naval District, (District Medical Officer), U. S. Naval Base, Philadelphia 12, Penna.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and case history review of the Board will be held on February 6 and the next Part II examination will be held on May 16. For further information and application blanks write to Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pa.

GRADUATE COURSE IN ENDOCRINOLOGY

Announcement is made of a five-day intensive course in endocrinology to be held in Los Angeles beginning February 23. For information write to Dr. E. K. Shelton, 921 Westwood Boulevard, Los Angeles 24.

RHEUMATISM SOCIETY ORGANIZED

Physicians interested in rheumatic disease are invited to participate in the newly formed *New Jersey Rheumatism Society* by attending a meeting at the Academy of Medicine (91 Lincoln Park, Newark), on Monday evening, January 26, at 8:30 p. m. For further information write or call any of the following: Dr. John W. Gray, 142 Clinton Ave., Newark Dr. Peter Warter, 717 W. State St., Trenton Dr. Harold Smith, 179 Lincoln Ave., Orange

OBITUARIES

DR. WALTER L. DUNNING

Dr. Walter L. Dunning, medical, dental and nursing supervisor in the Paterson school system, died suddenly on November 29, 1947.

Dr. Dunning was born in Paterson in 1876 and was graduated from Long Island Medical College in 1898. He served internship in the Lying-In Hospital, New York City and the Passaic General Hospital. Dr. Dunning was active in local fraternal and religious circles, and was a member of the staff of the Paterson General Hospital. During World War I, he was chief medical examiner for his district, and again served as a member of the medical staff in World War II.

DR. JOSEPH O. EVANS

Dr. Joseph O. Evans of Linden died on November 23, 1947, following a long illness.

Born in Frankfurt-on-Main, Germany, in 1893, Dr. Evans was educated in Frankfurt schools and attended universities in Wurtzburg and Frankfurt. He received his medical degree at the University of Frankfurt, served internship in hospitals in Breslau and Frankfurt and practiced as a surgeon and urologist in Hamburg.

Dr. Evans, who practiced medicine in Linden for the past four years, was a school physician and also physician for the Board of Health's child hygiene clinic.

DR. THOMAS M. GLASGOW

Dr. Thomas M. Glasgow, general practitioner and eye specialist for 37 years, died on November 29, 1947, at his home in Passaic.

Dr. Glasgow was born in County Tyrone, Ireland, and was graduated from the University of Dublin. He then attended school in Nova Scotia for two years. He studied pharmacy at the New Jersey College of Pharmacy, graduating in 1896. In 1899 he entered the University of Maryland Medical School, and received his medical degree in 1902. After interning at Maryland General Hospital, Dr. Glasgow practiced medicine in Newark and Greenwich, N. J., before settling in Passaic in 1908. At the time of his death he was on the staff of the Passaic General Hospital and the Newark Eye and Ear Infirmary.

DR. H. GARRET MILLER

On November 30, 1947, Dr. H. Garrett Miller died suddenly at his home in Millville. Death was due to circulatory collapse.

Born in Greenwich, N. J., in 1869, Dr. Miller attended the West Jersey Academy and South Jersey Institute in Bridgeton, and was graduated from the University of Pennsylvania Medical School in 1897. He established his practice in Millville that same year, specializing in obstetrics. Dr. Miller was very active in civic affairs and had served as president of the City Council for a term of three years, city physician, sanitary inspector, and from 1928 until his death, as Cumberland County Physician. He was elected president of the Cumberland County Medical Society in 1903, and was secretary of the society for 18 years.

DR. BYRON G. SHERMAN

Dr. Byron G. Sherman, president of the medical staff of the Morristown Memorial Hospital, died suddenly on October 9, 1947. He was one of the founders of the outpatient department of that institution. Dr. Sherman was born in Connecticut in 1887. His first interest was in the field of physical education, and for four years he was physical director of the Y.M.C.A. in Putnam, Connecticut. In 1917 he entered the medical school of New York University, receiving his M.D. degree in 1921. After an internship at the Newark City Hospital, he had a tour of duty as supervisor of the Convalescent Veterans Home in Ralston, and in 1925, he moved to Morristown, where he remained in private practice until the day of his death. He organized the outpatient surgical clinic at Morristown Memorial Hospital in 1926, and set up the tumor clinic there in 1938. He was director of outpatient services at the hospital for two decades and under his guidance it expanded from a 3-doctor unit to its present 50-doctor staff.

DR. SETH B. SPRAGUE

On November 23, 1947, Dr. Seth B. Sprague, one of the state's leading orthopedists, died in the New York Memorial Hospital. Born in Maine in 1876, he came to Jersey City in childhood. He was graduated from the medical school of the University of Maryland in 1908 and returned to Jersey City for practice. He soon became interested in the then young science of orthopedics and was invited to join the staffs of several local hospitals. Eventually he became attending or consulting orthopedic surgeon to the Jersey City Medical Center, the Christ Hospital, the A. Harry Moore School for Crippled Children, and the Hudson County Hospitals. He was an officer of the local chapter of the National Foundation for Infantile Paralysis, orthopedic consultant to the Public Service Corporation, and a Fellow of the American Academy of Orthopedic Surgeons. Dr. Sprague's standing in his community is, perhaps, best indicated by editorial comment in the Jersey *Observer* a few days after his death. "It was Voltaire who declared, that nothing was more estimable than a physician who pays equal attention to the rich and the poor. Dr. Sprague's long ministrations were a shining example of that precept."

ADVANCE PROGRAM—1948 ANNUAL MEETING

The next annual meeting of The Medical Society of New Jersey will begin on April 25, 1948. Watch for the February *Membership News Letter* which will give the daily schedule and an advance listing of the scientific programs.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

TUBERCULOSIS AMONG MILITARY INDUCTEES IN NEW JERSEY

Tuberculosis discovered in the examination of military inductees justified the efforts expended in having screening chest x-rays made of all persons called in the Selective Service during the war. A total of 6145 persons were brought to the attention of the state as deferred because of signs of tuberculosis. The names of those persons were referred to local agencies with the object of urging each patient to submit to a more complete examination. Subsequent records of examination by family physicians or at clinics revealed 4222 cases of tuberculosis among this group. Of these, 1275 were cases of active tuberculosis.

An amazingly high ratio of these active cases (located as a result of the screening examination) had not previously been recognized as tuberculosis. In fact 1017 or about *80 per cent of the active cases had not been previously reported.*

The location of this large group of cases of active tuberculosis in New Jersey is a case finding accomplishment of great importance. Moreover, it demonstrates the value of chest x-ray screening examinations even of persons apparently in reasonably good health.

In the follow-up of the deferred inductee, much credit is due to employees of the state and county Tuberculosis Associations and also to chest clinics and physicians. Full credit should also go to the Advisory Committee on Tuberculosis of The Medical Society of New Jersey, its Chairman Dr. A. E. Jaffin and his associates including Drs. S. B. English, Martin Collier, Joseph Morrow and Joseph E. Runnells and also to Dr. Norman Scott for their early efforts to initiate the pre-enlistment x-ray screening of all inductees and volunteers and for aid rendered by them and others particularly during the early days of the program of examination.

ADEQUATE DOSAGE IN WHOOPING COUGH IMMUNIZATION

Maximum protection against pertussis by immunization is dependent on adequate total amounts of H. pertussis, given in multiple doses. When a fluid vaccine is used, 80 to 100 billion organisms should be given; 30 billion, if an alum precipitated vaccine is used.

Many multiple antigen preparations consist of alum precipitated diphtheria toxoid in fluid pertussis vaccine. It is, therefore, necessary to give additional doses of pertussis vaccine to secure adequate dosage. Four, five or six week intervals between doses are preferable to short (one-week) intervals. See *The Control of Whooping Cough in New Jersey.**

DISCONTINUANCE OF STATE GONOCOCCUS CULTURE LABORATORY

The gonococcus culture service carried on by the State Department of Health for the past five years was discontinued January 1, 1948. Five years ago, when this service was established, gonorrhea was a very unsatisfactory disease to handle. It was responsible for many of the pelvic operations on women. Any procedure which promised better medical care was important at that time; therefore, the culture service was undertaken after experimental work which demonstrated this laboratory procedure to be more reliable than smears, and after a satisfactory method for mailing specimens had been worked out.

With pencillin, the expense of maintaining the gonococcus culture laboratory no longer seems justified. Physicians are urged to treat suspected cases with penicillin immediately, rather than to delay treatment for laboratory confirmation. Clinical symptoms or history of exposure during the incubation period, warrant treatment with penicillin. This non-toxic antibiotic cures most cases of gonorrhea so quickly that it is good medical practice to treat when in doubt. Prompt treatment of contacts is necessary to prevent reinfection. Arrange for treatment of the patient and his sexual partner at the same time if possible.

* Published by the N. J. State Department of Health and available from the Department on request.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

The regular monthly meeting of the *Medical Society of Atlantic County* was held on Friday evening, December 12, 1947, at the Traymore Hotel with Dr. Clarence Whims, the president, presiding. The guest speaker of the evening was Dr. Charles W. Dunn, Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania. His subject was *The General Practitioner and Endocrinc Therapeutic Problems.*

Dr. Dunn opened his presentation by discussing the management of endocrine disorders and its associated problems. A complete endocrine diagnosis is essential, otherwise the physician is hampered with the proper therapy. Of no less importance are the determination of the degree of deficiency, its duration and whether or not it is progressive; the determination of therapy, the maintenance of therapy and finally its prognosis. And with the determination of the operation of the glandular structures, consideration must be given to their inter-relation with other glands of the body. A complete examination of the body is a prime necessity and includes x-ray of the skull, pneumo-peritoneal examination, air injection around the adrenals, blood chemistry, urine examination, vaginal smears, and glucose tolerance tests. These are the collateral tests which help in diagnosis but are not all important measures utilized. An endocrine case must be approached with a study of the pituitary gland, the master gland of the body, which secretes ten or more hormones, chief of which are the thyrotropic, adenocorticotropic, parathyrotropic, gonadotropic and the diabetic glucose factor.

He stressed the pitfalls which are encountered in all these deficiencies and the measures which must be followed in the proper evaluation of each case before proper therapy can be instituted.

A very lively discussion followed, opened by Drs. Stewart and Konzelman. On behalf of the members present, the president expressed his thanks for a most instructive and interesting presentation.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society,* held at Bergen Pines Hospital, Oradell, on the evening of November 11, 1947, was called to order by the president, Dr. Rudolph C. Schretzmann, at 9:18 p. m.

The minutes of the regular meeting of October 14, 1947, were accepted as read by the secretary.

Dr. Charles Littwin, Chairman of the Entertainment Committee, reminded the members of the Annual Banquet to be held at the White Beeches Country Club, Thursday evening, November 20, 1947, and said that to date only 71 members had signed their intentions to attend the dinner. He reported that he had secured entertainment of the highest type, and hoped that many additional members would mail in their requests for tickets.

On recommendation of the membership committee, the following applicants were elected to full membership: Drs. Stephen Bednarz, Wallington; Edward Dana, Hackensack; Peter G. Hunziger, West Englewood; Vinicio G. Liva, Lyndhurst; Amedeo C. Naclerio, Wood-Ridge; Monroe E. Neuman, Hackensack, and Thomas J. Sperber, Teaneck. Drs. Leo P. Shultz, Allendale, and Gustav G. Steneck, Bogota, were elected to associate membership. Dr. Leon J. Schwartz, Rutherford, was elected to regular membership by transfer from Cumberland County.

The following doctors, who formed the panel of the evening round table discussion on *"Hypertension. Is Surgery the Answer?"*, were introduced by Dr. Lee Solworth: Dr. William Goldring, Assistant Professor of Medicine, New York University Medical College, Chief of Hypertension and Nephritis Division, Bellevue Hospital, New York City; Dr. Bronson S. Ray, Neuro-Surgeon, Assistant Professor Neuro-Surgery, Cornell Medical College, Attending Neuro-Surgeon, New York Hospital; Dr. Leroy W. Black, Hackensack Hospital; Dr. G. Barton Barlow, Englewood Hospital, and Dr. Lee Solworth, Englewood Hospital.

Prior to question and answer period, Dr. Ray gave a brief talk on *"The Present Day Surgical Approach to Hypertension"*, and also pointed out that the surgeon doing hypertension surgery should know: (1) Who will probably be benefited; (2) who will not be benefited, and (3) the risks involved. It was his opinion that operation to relieve subjective symptoms is unjustified, that operation is justified only on the basis of objective improvement as evidenced by : (1) decrease in blood pressure; (2) decrease in cardiac enlargement, and (3) the return of the EKG to a more normal configuration. He definitely pointed out the bad risks as: (1) young people with a recently acquired labile hypertension; (2) those over fifty years of age; (3) the obese; (4) the psychotic; (5) recent coronary occlusion; (6) heart block; (7) those showing congestive failure which is not easily relieved, and (8) those showing poor kidney function.

The meeting adjourned at 11:15 p. m.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

On December 11, 1947, the *Burlington County Medical Society* held its regular meeting at the Riverton Country Club. Dr. E. Warren Rodman, the president, presided and introduced the speaker of the evening, Dr. Robert S. Garber, Clinical Director of the State Hospital at Trenton.

Dr. Garber stated that the hospital opened in 1848 and during the first year 70 patients were admitted. The total admissions for the past one hundred years has totaled 45,000. At the present time 3400 patients are admitted yearly. About 53 per

cent are discharged each year and are placed on probation for six months or longer. Although Dr. Garber did not have a title for his speech he explained the proper proceedings for the commitment of mental cases to the hospital and also the modern hospital treatment of psychotic patients. There are two types of commitment papers, first the regular and second the voluntary. In discussing the regular commitment papers Dr. Garber pointed out that the law requires that the applicant's form must be signed; that two physicians must examine the patient, fill out their part and sign it; a notary public must notarize the three signatures; and lastly, a judge must review the case and sign his part. In case of an emergency the only part that may be omitted temporarily is that part concerning the judge which can be completed at a later date. Dr. Garber said that there must not be any deviation from these requirements. In regard to the voluntary commitment any person who has been a resident of the state for one year may sign his commitment papers for treatment. However, if he wishes to be released from the hospital he must give ten days' notice. During this ten-day period the patient is thoroughly examined both physically and mentally to determine whether or not he is safe to return to society. Alcoholics are not permitted to sign a voluntary commitment but may be admitted with a regular commitment if psychotic. Voluntary commitments for syphilitics for fever therapy are permitted and are usually for a period of three months. The speaker then described in a general way what happens to a patient after admission. There is a very thorough examination using x-ray, laboratory studies and any other special studies which might be indicated. All studies, examinations and special reports on a patient must be completed within 30 days at which time the patient is presented to the hospital staff for diagnosis and recommendation of treatment. Dr. Garber briefly described the various treatments which the hospital is equipped to give. A new treatment called hypothemia which is the lowering of the patient's temperature was described and apparently has great possibilities. However, it is too new to make any definite statements at this time. The staff of doctors at the hospital is made up of specially trained men and there are numerous consultants who are called in whenever necessary.

Dr. Perry S. MacNeal transferred his membership from the Philadelphia County Medical Society to the Burlington County Medical Society.

Dr. S. Emlen Stokes, reporting for the Welfare Committee, stated that the new regulations concerning the Old Age Assistance will be sent to all members. Also new bill forms will be mailed to each doctor as soon as they are printed.

Dr. Bray, liaison officer between the Public Relations Committee and the Woman's Auxiliary of the County Society, presented a four point program which the Auxiliary would like to put into effect. The plan was discussed and finally adopted.

The Public Relations Committee of the County Society is to sponsor a program on cancer.

MIDDLESEX COUNTY

Carlyle Morris, M.D., Reporter

A special meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, on November 5, 1947, to continue discussion of the proposed revision of the Constitution and By-Laws, and Principles of Medical Ethics, with Dr. Frederick S. Taber, president, conducting the meeting.

The revised Constitution and By-Laws was officially adopted by the Society as presented by the Chairman of the Committee on Revision, Dr. Marshall Smith. The most important change was the provision establishing a Board of Trustees of the County Medical Society with the important duties of establishing policies of the Society and coordinating the different activities of the medical profession.

Time did not permit consideration of the Committee's report on revision of the Principles of Medical Ethics, Dr. F. M. Hoffman, Chairman, and with reluctance this piece of unfinished business must be passed along to our successors in office.

A formal report of the Cancer Committee, Dr. F. M. Clarke, Chairman, was presented for study and consideration of the Society. This report stressed the responsibility of the medical profession for the early recognition and treatment of malignancy. The added responsibility for cooperation with and advising lay bodies on the most effective manner of employing funds for the control of cancer was emphasized as resting primarily with the medical profession, if this important activity is to accomplish the greatest benefit.

The regular monthly meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, November 19, 1947, at 9 p. m. In the absence of the president, Dr. Edward F. Klein, vice-president, conducted the meeting.

The following were elected to membership: Dr. W. S. Freeman, Highland Park, to regular membership, having been an associate member for two years; Dr. Xavier A. Budnicki, Perth Amboy, to associate membership.

The Program Committee Chairman, Dr. A. J. Pellicane, announced that the Annual Dinner meeting will be held at the Roger Smith Hotel, New Brunswick, December 17, 1947, at 7 p. m.

Dr. F. M. Hoffman, Chairman of the Nominating Committee, recommended members for the offices of the Society for the year 1948; the Board of Trustees; Delegates and Alternates to The Medical Society of New Jersey, the State Nominating Committee, and the Medical Ethics Committee to be balloted upon at the annual meeting in December.

Dr. Murray B. Jacobson made a final report of the activity of the Veterans Administration Committee of the Society. He announced that a surplus of $120.00 after payment of all loans and obligations, would be donated to the County Medical Society.

This monthly meeting of the Society was made the occasion of a joint meeting with the members of the Middlesex County Pharmaceutical Association. Dr. Edward Klein of the Medical Society.

and Mr. Joseph Silk, president of the Pharmaceutical Association, expressed mutual pleasure of the members of the two societies in the common ideal of service in the professions. Dr. Schick, Associate Professor of Pharmacy in the New Jersey College of Pharmacy, and Superintendent of Perth Amboy Hospital, emphasized the necessity of a close acquaintance with the many problems now coming before the two societies.

Those present had the pleasure of hearing an excellent talk by R. C. REAGER, Professor of Public Speaking at Rutgers University. The subject of Professor Reager's talk—"A Prescription for Professionals" was very interestingly developed as to its different ingredients, the most important of which were: the employment of correct English, the cultivation of a pleasant and modulated voice, a cheerful and confident manner of speech, and the employment of concise and understandable terms in our conversation with lay individuals. He especially emphasized the importance of gaining the confidence of the individual at once by the manner of the physician's speech. He stated that this basic relationship was common to all human activities.

The Society extended a vote of thanks to Professor Reager for his interesting and instructive talk; and to Dr. A. J. Pellicane, Chairman, Program Committee, for his services throughout the year in securing able and interesting speakers.

On adjournment, a collation was served in the dining room of the Roosevelt Hospital, through the courtesy of the Board of Directors of the Hospital and the Medical Director and Superintendent, Harry J. White.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

Although it was Thanksgiving Eve, attendance at the regular meeting of the *Monmouth County Medical Society*, held at the Monmouth Memorial Hospital in Long Branch, was excellent. Guest speaker was DR. GEORGE C. ORNSTEIN, Professor of Medicine, New York University College of Medicine, and Director of Medicine at the Metropolitan Hospital in New York. Dr. Ornstein's paper on *Carcinoma of the Lungs* was illustrated by lantern slides. The talk was interesting and warranted the good attendance.

Dr. Ornstein discussed the signs and symptoms of the various types of lung carcinoma. These tumors may be silent for years and are thus often discovered too late. It has a tendency to early metastasis. Earliest signs are picked up by the stethoscope. X-ray may be negative for a long time. Bronchoscopy and bronchial washings are of value if they are positive but worthless if negative. Treatment is surgical. X-ray may be of temporary value and give some relief but should not be relied on in treatment.

Discussion was opened by Dr. Altschul. Other members of the society representing various specialties took active part in the discussion.

The business part of the program followed. The work of Dr. Altschul and Dr. Blaisdell in conducting a survey of the hospital needs of Monmouth county was commended. A special committee to carry on this work was appointed. The committee on Crippled Children and the Conservation of Sight and Hearing was discarded and two separate Committees appointed. Dues for 1948 were set at $50. With a slight decrease in state dues, it was voted to keep the dues as they are now and thus accumulate a surplus in the treasury.

The following were elected to membership: DR. VINCENT WHELAN of Red Bank, and DR. HAROLD McGREVEY of Spring Lake.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held jointly with the Passaic County Dental Society on Tuesday evening, November 18, 1947, at 9 p. m., in the Freeholders' Meeting Room, Administration Building, Paterson.

No business session was held prior to the scientific program and DR. LEON E. DE YOE, president of the County Medical Society opened the meeting by introducing DR. VICTOR BOYKO of the Dental Society who presented the speaker of the evening, DR. J. J. STETZER, JR., Assistant Professor of Clinical Oral Surgery at Temple University Dental School, Philadelphia and Assistant Chief of Oral Surgery at the Pennsylvania Hospital, Philadelphia, Pa. Dr. Stetzer's address on "Diagnostic Symptoms of Oral Manifestations of Disease" was illustrated with lantern slides, and was exceptionally interesting and educational. Following Dr. Stetzer's paper, there was much interested discussion.

SALEM COUNTY

D. G. Neander, M.D., Reporter

DR. SAMUEL RYNES of Philadelphia was the principal speaker at the regular meeting of the *Salem County Medical Society* held on November 21, 1947, at the DuPont Penns Grove Club. Dr. Rynes' subject was *Allergy and Newer Treatment*. The pathology of allergy was briefly discussed, the role of histamine being stressed. Actions of the various anti-histaminic drugs were presented. This discussion included some of the newer drugs not yet in use. The uses of the anti-biotics in bronchial asthma were presented, and drug allergy versus drug intolerance was discussed. Dr. Rynes concluded his paper by presenting specific examples of allergic reactions to thiamin chloride and the glandular extracts.

MR. JAMES E. BRYAN, the new executive officer of the State Society, gave the members a picture of the organization of the State Society, and described its aims and objectives. The members were asked to give their support to help achieve these aims.

The business part of the meeting was then opened by the president, DR. WILLIAM H. MILLER. The minutes of the last meeting were approved as read. A motion was passed to have the meetings start at 4:30 p. m., and to have the scientific portion precede the business portion of the meeting.

After adjournment, the members gathered in the dining room for dinner.

WOMAN'S AUXILIARY

CHICAGO CONFERENCE

Mrs. Luther Kice, chairman, opened the Chicago Conference of the Woman's Auxiliary by speaking of the enrichment given to our lives by the Auxiliary, and the necessity of rededicating ourselves to this work to maintain the high standards of the American Medical Association and professional freedom. There is much opportunity and responsibility for Auxiliary leadership in health education. Let it not be talk, but action with the advice of the Medical Society. Leadership is native ability plus training, experience and study. Opportunities are at our doorstep, bringing responsibilities. We should be of service to the medical profession, the community, state and nation.

Mrs. Allen, the National Auxiliary President, stressed the goal of doubling our membership and of doing better public relations. She recommended increasing the national dues, and raising the dues to include the distribution of the *Bulletin* to every member.

Mrs. Kice gave a dietary warning: due to the high prices of our food, serious results may come to the children of the country. We should be of help in forming local health departments; we should be watching milk, water supplies (most especially keeping them free of pollution by industrial waste), food handling, farmers' market, and when necessary, laws enacted to protect public from open markets.

Mrs. Schaefer, the national legislative chairman, outlined her ten-point program::

1. Informed alert membership.
2. Continuous study of what is going on in individual state.
3. Periodic news letter during legislative session, giving all state and local developments as they occur.
4. Up to the minute news at every meeting.
5. Every member with a knowledge of the ten-point health program of the American Medical Association.
6. Constant reading of the medical JOURNAL.
7. Active legislative committee in every Auxiliary.
8. Closer consultation and cooperation with the Medical Society.
9. Frequent contact with senators and congressmen.
10. The periodical "Check and Double Check".

Mrs. Briendenstein, State Senator of Montana, the only doctor's wife who is an active legislator, was introduced, and said that wives of physicians should take a more active part in politics. Machines are powerful, and your weight depends on the votes you carry; but on the whole legislators are not as powerful as they would have you believe they are. She gave the following concrete example which happened to her as chairman of the committee conducting hearings on hospital licensure: The doctors of the state had excellent legal talent, but when they had finished testifying and had left the room, the other members of the committee turned to her and said: "Eleanor, what shall we do?".

Dr. Thomas Clarence Routley, secretary of the Canadian Medical Association and chairman of the Council of the World Medical Association described the work of the W.M.A. One hundred and twenty-five, representing 48 nations, established the organization on a constitutional basis. The objects of the organization are two fold:

1. Assist all people of the world to obtain the highest possible level of health.
2. Promote peace.

Dr. Bortz said the medical profession is dedicated to the sole end of bringing life more abundantly to our fellow men. The Woman's Auxiliary is the greatest single asset, one sadly neglected, the finest public relations council, but one not yet appreciated. Medicine has a great role to play in this the most exciting era in the human race. The world is divided into two camps:

1. State of government dedicated to dictatorship, grinding individual into the state.
2. Government whose keystone is the rights of man and the sanctity of the home.

Dr. W. W. Bauer spoke of the typical day, if you lived according to the rules, and said the trouble up to now with health education was that it had been made so infernally unattractive. The series called *Time Out* started November 13 with entertainment comparable to the best in radio. The Auxiliary was cautioned that there was more to radio than just dumping the records at the station. The radio station must feel that it is serving the people of that community. If a series is put on, we have the responsibility of publicizing it; of organizing listening groups with friends who

are not Auxiliary members; we must call the radio station and tell them we liked the reception. If you don't like it, write to us, not to the radio station, telling us specifically what was wrong. There is competition for radio time, and we have a responsibility for its utilization. The Bureau of Health Education is working on school health problems, and it is hoped that the Auxiliaries will start action in establishing policies acceptable to the Medical Societies, the Department of Education, and the PTA's.

Mr. Cooley, secretary of the Blue Shield Voluntary Prepayment Medical Care Plans, said that any form of compulsory health "insurance" is not insurance, but taxation. Health cannot be insured; and if so, it would be only by preventive medicine. It is really sickness insurance. There are 91 plans in 37 states at the present time, with 23 functioning in the state of Washington alone. Each of Washington's valleys has its own plan, making it the only state in the union with complete coverage.

Hygeia will celebrate its 25th anniversary this April. School subscriptions should be followed up and interest in the use of this magazine to teach health in the schools stirred up by sending the suggested outline of questions for classroom use to the teachers. *Hygeia* now carries one article a month for dentists, and the half price rate has been extended to the members of this profession. Our legislators should be sent a subscription of this publication. Fifty per cent of the auxiliaries do nothing for *Hygeia;* 20 per cent of the auxiliaries do 95 per cent of the work for this magazine.

Dr. Jules Masserman, Director of the National Foundation for Psychiatric Research, read a scholarly paper on *Mental Health in a World Crisis.* Every human being is motivated by the desire to survive and to propagate. If normal human adaptation is frustrated, the pattern becomes regressive and infantile. If there is inner striving, pattern becomes conflicted, deviated, digressively neurotic and increasingly unrealistic.

If hostility is to be held in check, nations must understand each other and not seek to make other nations adopt patterns in our own image. There must be individual freedom and economic security. We deprecate any impending threat in order to justify and rationalize our desultory action. Such opiates become the religion of the people until acts of panic-ridden violence lead to war, want and intolerance. In the United States there are eight million mentally ill; three million chronic alcoholics; one out of fifty is destined to commit suicide; and one out of fourteen will be confined at some time during his life to a mental hospital. The bacteriologic war of day after tomorrow will kill all too quickly. It is imperative that we no longer ignore the basic needs of the world; nor seek to impose on it our pattern of life; nor the machinations of power politics. There is a great need for trained psychiatrists; only 3000 practice in the United States, of whom only 1800 are diplomates of the American Board of Psychiatry.

Mrs. Allman's report was excellent. Her motto, "Every physician's wife a member" should be kept in mind if we are to double our membership. The Conference brought three recommendations to the Board of Directors of the Auxiliary:

1. That we increase the national dues.
2. That state presidents study the national finances and convey this information to their respective members.
3. That committee members of the standing committees of the National Auxiliary be invited to attend the Conference without the right to vote.

In closing I should like to say it has been an inspiration and an honor to have represented you at this Conference. I was proud to present to them the wonderful work that my Auxiliary chairmen have been doing, and the splendid results obtained up to this point. Thank you, each and all.

FRANCES MANCUSI-UNGARO, President.

AUXILIARY REPORT

WARREN COUNTY

Mrs. Herman Smith
Chairman, Press and Publicity

Under the chairmanship of Mrs. Walter Boquist, president, the *Woman's Auxiliary to the Warren County Medical Society* held its monthly meeting on October 20, 1947, at the Phillipsburg Elks Club.

The President announced that an oxygen tent had been purchased for the Pediatric Department of the Warren Hospital as a gift from the Auxiliary.

The following newly elected officers were present: *President,* Mrs. Walter Boquist; *Vice-President,* Mrs. Joseph C. Humbert; *Treasurer,* Mrs. Paul F. Drake; *Secretary,* Mrs. Charles Potter. Two new members were welcomed: Mrs. Raymond Cooper of Washington and Mrs. Francis E. Martin of Belvidere.

BOOK REVIEWS

Radiology for Medical Students. By Fred Jenner Hodges, M.D., Isadore Lampe, M.D., and John Floyd Holt, M.D. Pp. 424 with 103 plates. Chicago, Year Book Publishers, Inc., 1947. $6.75.

This book is intended for medical students, and endeavors to teach the fundamentals of diagnostic and therapeutic radiology. Part I of the volume covers diagnostic radiology and is 247 pages long. The physics of diagnostic radiology is discussed.

The methods for radiologic examination of the regions of the body are described, and excellent illustrations of x-ray films of the more important pathologic entities are included. The explanatory text is concise and lucid.

Of interest to radiologists in particular, is the method outlined by the authors for the filing and cross-indexing of roentgen-ray records. This was previously described by the authors in the literature.

Part II (152 pages long) is devoted to therapeutic radiology. The physical and biologic principles underlying radiation therapy are clearly explained.

The benign and malignant conditions amenable to radiation therapy are discussed under each region of the body. The radio-curability, prognosis, and approximate amount of therapy required are discussed. The associated surgical or medical therapy are also mentioned.

Most other books on radiation therapy are intended for specialists. The authors have been successful in presenting their material in a concise, palatable and well coordinated manner, which affords the reader a grasp of the important tangible facts and leaves the rare diseases and debatable theories to more advanced texts.

JULES H. BROMBERG, M.D.

Introduction to Medical Psychology, by L. Erwin Wexler, M.D. Pp. 171. Grune and Stratton, New York, 1947. $3.50.

This slim volume sets its sights at those physicians whose major field of interest is not psychiatry. Unlike many elementary books on the subject, it gives adequate attention to the social and cultural forces which mould human personality. There is a particularly good explanatory chapter on psychologic tests which tells the curious physician what these procedures are about, though of course there is no attempt to demonstrate how to administer or interpret the tests. The bulk of the book is a presentation of elementary psychology including a rapid but comprehensive review of modern concepts in the field of emotions, instincts, habits, complexes, intelligence, character, temperament and personality. There is no effort to furnish any material in clinical psychiatry. The volume will give the unsophisticated physician some background in the field of psychology. It promises nothing more and it accomplishes nothing less.

ARNOLD M. KALLEN, M.D.

The 1946 Year Book of Industrial and Orthopedic Surgery, ed. by Charles F. Painter, M.D., Pp. 432 with 225 illustrations. Chicago, 1947, Year Book Publishers, $3.

This is a comprehensive resume of the most interesting and important subjects in orthopedic surgery and industrial medicine published in 1946. Of particular educational interest to all surgeons is the chapter on osteomyelitis. The classification, types and methods of treatment, both operative and non-operative, reveal a marked change in attitude and mode of treatment compared with ten years ago.

The newer aspects of the etiology, pathology and treatment of the various arthritides is concretely reviewed in a revealing manner. Acute anterior poliomyelitis is likewise effectively reviewed, particularly with reference to the present day treatments.

Lesions of the extremities and spine are briefly discussed with an adequate and clarifying review of ruptured disc. The manner of treatment, conservative and surgical, is discussed at some length.

The latter part of the volume provides a comprehensive review of industrial medicine and surgery, referring particularly to toxicology, infections and special hazards in industry.

The *Year Book* is a well-planned and edited volume of pertinent subjects, which aids in clarifying and reviewing many important and controversial subjects of daily interest at this time.

JOHN J. FLANAGAN, M.D.

Clinical Allergy. By Alexander Sterling, M.D., assisted by Bea Sterling Hollander, A.B., M.D. Pp. 198. Figures 16. New York. International University Press. 1947. $5.00.

This well-written monograph by a capable allergist joins the multitude of treatises on the subject which have flooded the market recently. Unlike Cooke, Feinberg, Criep, Gay, Urback, etc., who presented fully detailed textbooks covering all phases of allergy, anaphylaxis and immunology, Sterling avoids theory, and attempts to guide the general practitioner through a maze of varied technics. What the author aims to do is to show the right way to give the right drug at the right time and in the right dosage.

Most of the subjects are presented clearly and concisely with proper emphasis given to the important problems in management.

The author has found that by giving "desensitization" injections at daily intervals, better results can be obtained. He feels that the usual 5 to 7 day intervals between injections may be the cause of some failures.

Very little is written about the newer antihistaminic drugs because they were still in the experimental stage at time of publication.

The subject of skin testing with bacterial proteins is discussed at great length. Most allergists pay little heed to these tests because of their nonspecificity.

WILLIAM GREIFINGER, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **January, 1948** **No. 1**

THERE probably never has been a period when a clear understanding of "activity" in tuberculosis was more important than now. The use of the miniature film technique by the military services and in industrial and community surveys has made the public "chest X-ray conscious." In mass X-ray surveys of apparently healthy groups, the majority of the cases of tuberculosis discovered are neither obviously active nor obviously healed but require extended study and observation to determine the presence or absence of activity.

THE DIAGNOSIS OF ACTIVITY IN PULMONARY TUBERCULOSIS

There is no single word in the vocabulary of clinical tuberculosis more widely employed nor more widely misunderstood than the word "activity". The ancient fallacy still persists that rales arise in moisture, which signifies inflammation and hence, activity. Another more dangerous fallacy is that activity is usually accompanied by slight changes in temperature, pulse, weight, appetite and physical energy.

The two essential requirements of a scientifically sound and clinically useful concept of activity are that it must be securely based on the anatomic state of the tuberculous lesion and must also be synonymous with need for treatment. Such a concept must include three distinct groups of cases: those which show anatomic progression; those which are anatomically stationary but not healed; and those which are retrogressive but not yet safely healed.

In determining whether or not a case requires treatment, the symptoms, physical signs, laboratory data, and X-ray picture may all be used—or misused.

The symptoms of pulmonary tuberculosis are familiar to all physicians. When a group of them is present there is usually no doubt about activity. When only one or two of them are present they may be erroneously attributed to the minimal lesion shown in the X-ray film. Serial films are the only safeguard against this error.

A more common and more serious error is to exclude activity because of the absence of symptoms. It cannot be emphasized too strongly that tuberculosis, both in its onset, and during the early period of relapse, is characteristically a symptom-free disease. To depend upon symptoms, or to await the development of symptoms, is to lose the most favorable moment for treatment. Surveys have shown that when the diagnosis is based upon symptoms, 87 per cent of the cases will have advanced disease. Increasing numbers of hospital beds are filled with patients whose symptom-free, early disease was discovered in a survey or induction examination a year or so earlier, but who refused treatment and continued to work until they felt sick and had advanced disease. The public requires education on this matter; let us hope that most of it will be forthcoming from physicians.

Physical signs are of still less value than symptoms in determining activity. Inspection, palpation, and percussion are not to be trusted and auscultation is but little better. Coarse, or moderately coarse, moist rales, do usually indicate activity. They are often absent, even in far-advanced disease. Conversely, rales of the fine, or moderately coarse, dry type are often present throughout the entire life of a person with well-healed tuberculosis.

Like symptoms and physical signs, the laboratory helps us out by confirming a suspicion of activity, but does not exclude it. The finding of tubercle bacilli in the sputum, or in the gastric contents is always an indication for treatment and careful search should never be neglected.

Blood studies as a guide to activity are of little

use to the doctor in practice. Most clinicians agree that the X-ray picture is a more accurate, sensitive, and dependable barometer of intrapulmonic weather than the blood picture.

The superiority of the X-ray film over other guides to activity in pulmonary tuberculosis makes it important that we recognize its limitations and use it to the greatest advantage. It requires little experience for anyone to learn to recognize the "soft" shadows, with indistinct borders which signify the active exudative, pathological reaction, and the "hard" shadows, partly or largely linear and with sharply defined borders, which signify a well-healed fibrotic reaction. Between these two extremes is a large group of cases in which the most experienced and expert interpreter will be unable to differentiate active from inactive disease by a single film. In these cases there is no substitute for the careful and detailed comparison of serial films made at intervals of one to three months.

In making comparisons of films it is important to keep in mind certain sources of error. The degree of exposure, the depth of inspiration and position of the patient in relation to the cassette may give illusory effects if the films being compared are not carefully checked for these factors. Slight differences in projection angles or changes in the position of the clavicles may reveal shadows which were partially concealed in the earlier film, thus giving the illusion of progressive disease or *vice versa.*

The Diagnosis of Activity in Pulmonary Tuberculosis (with case reports and illustrative films), Raymond C. McKay, M.D., Postgraduate Medicine, May, 1947.

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*Dolkart, R. E.; Dentler, M., and Barrow, L. L.: The Effect of Various Types of Therapy in the Management of the Irritable Bowel Syndrome. Illinois M. J. 90:287 (Nov.) 1946.

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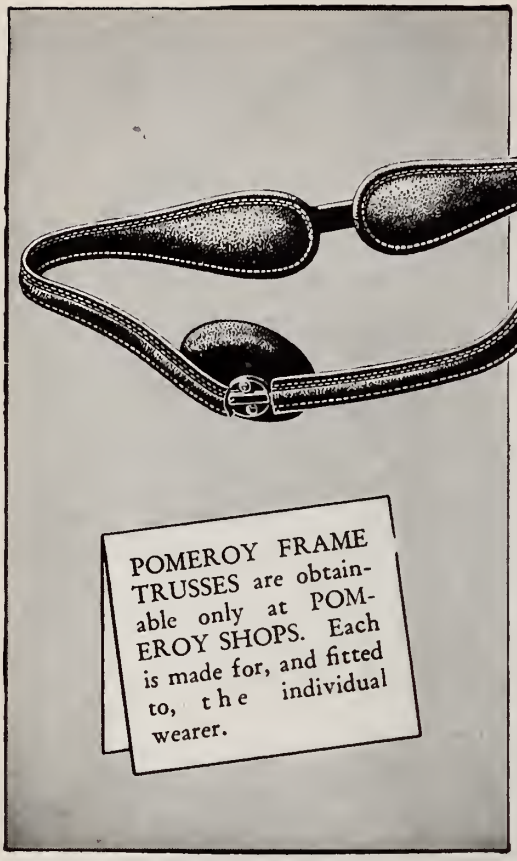
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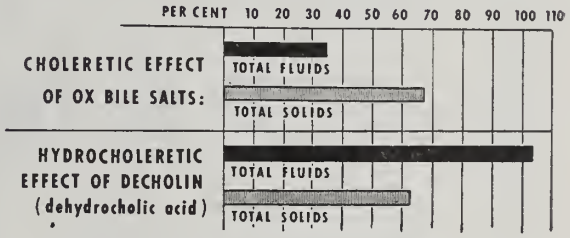
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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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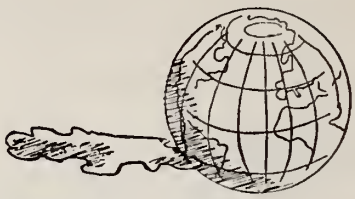
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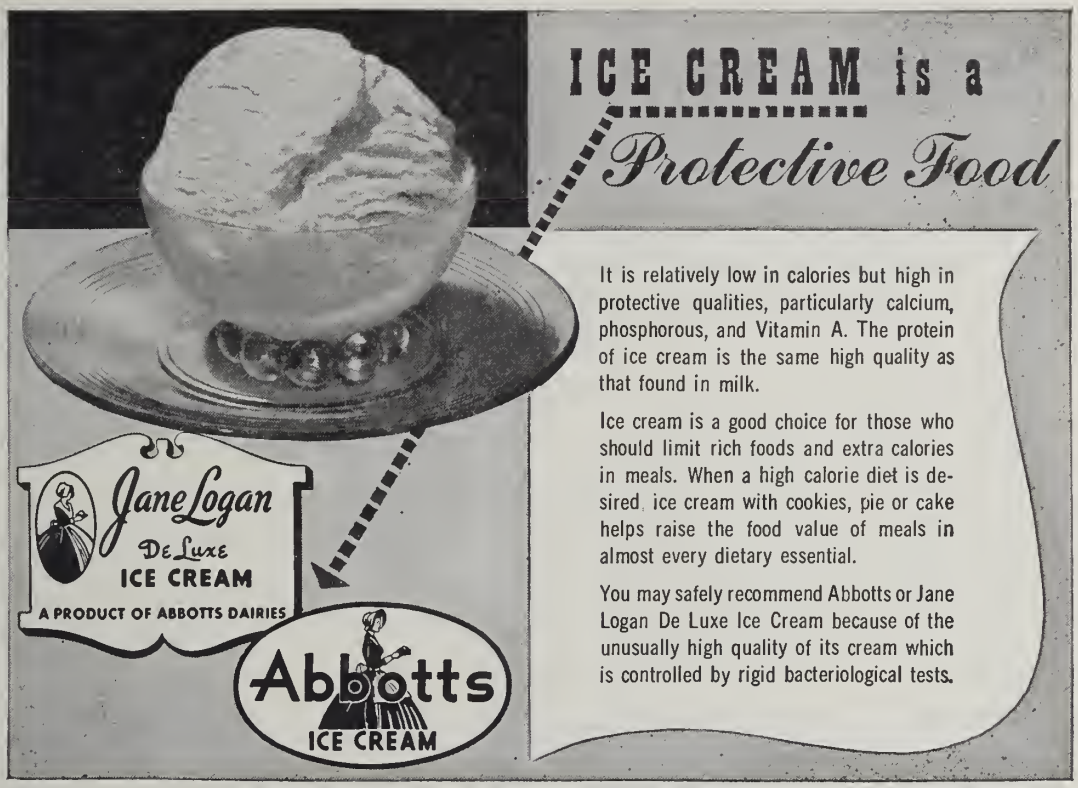
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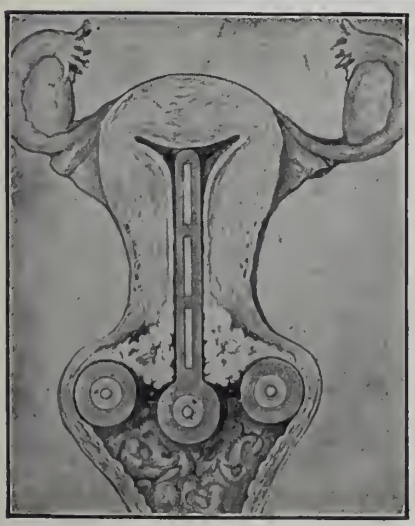
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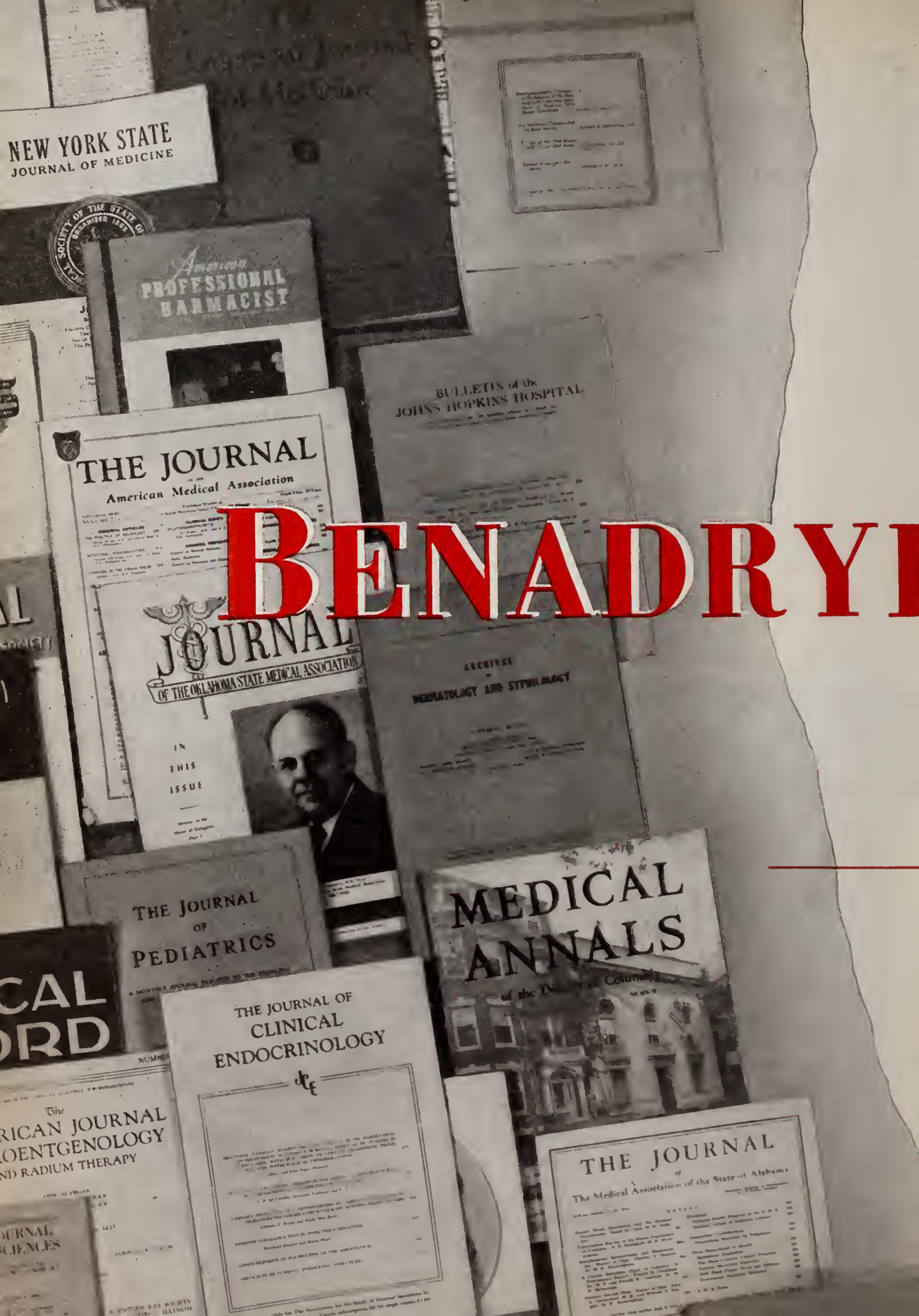
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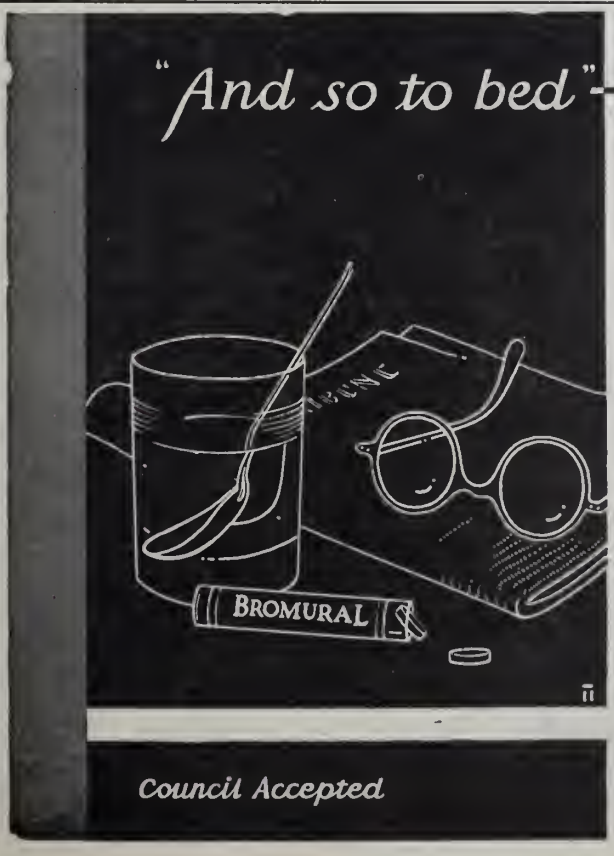
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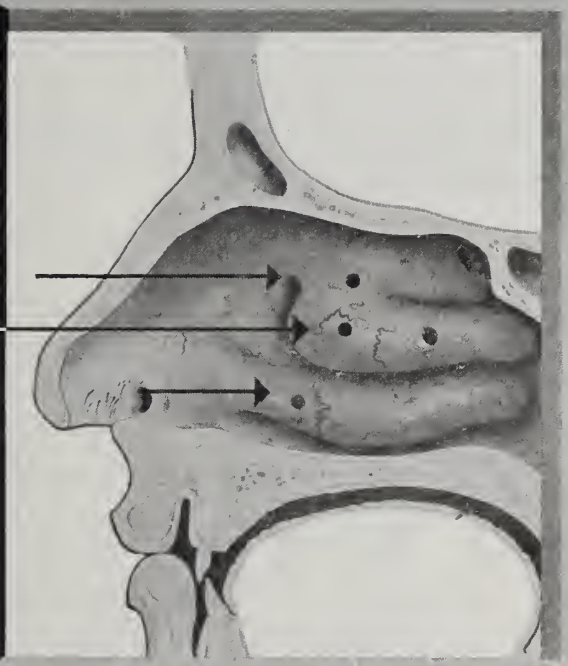
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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*BOGERT, L. J.: *Nutrition and Physical Fitness, 4th edition, 1943, Chapter IX, p. 22.*

**A.M.A.: *Handbook of Nutrition, 1943, p. 360.*

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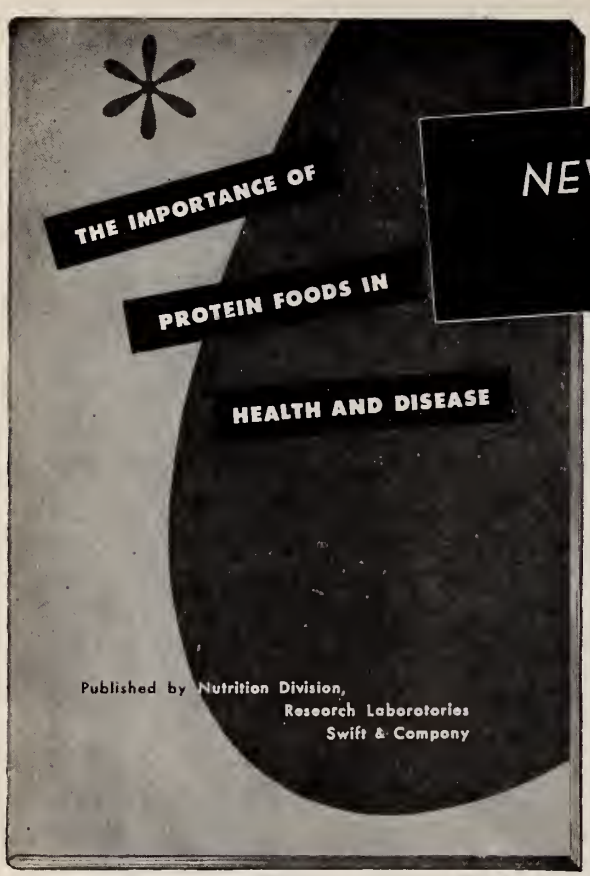
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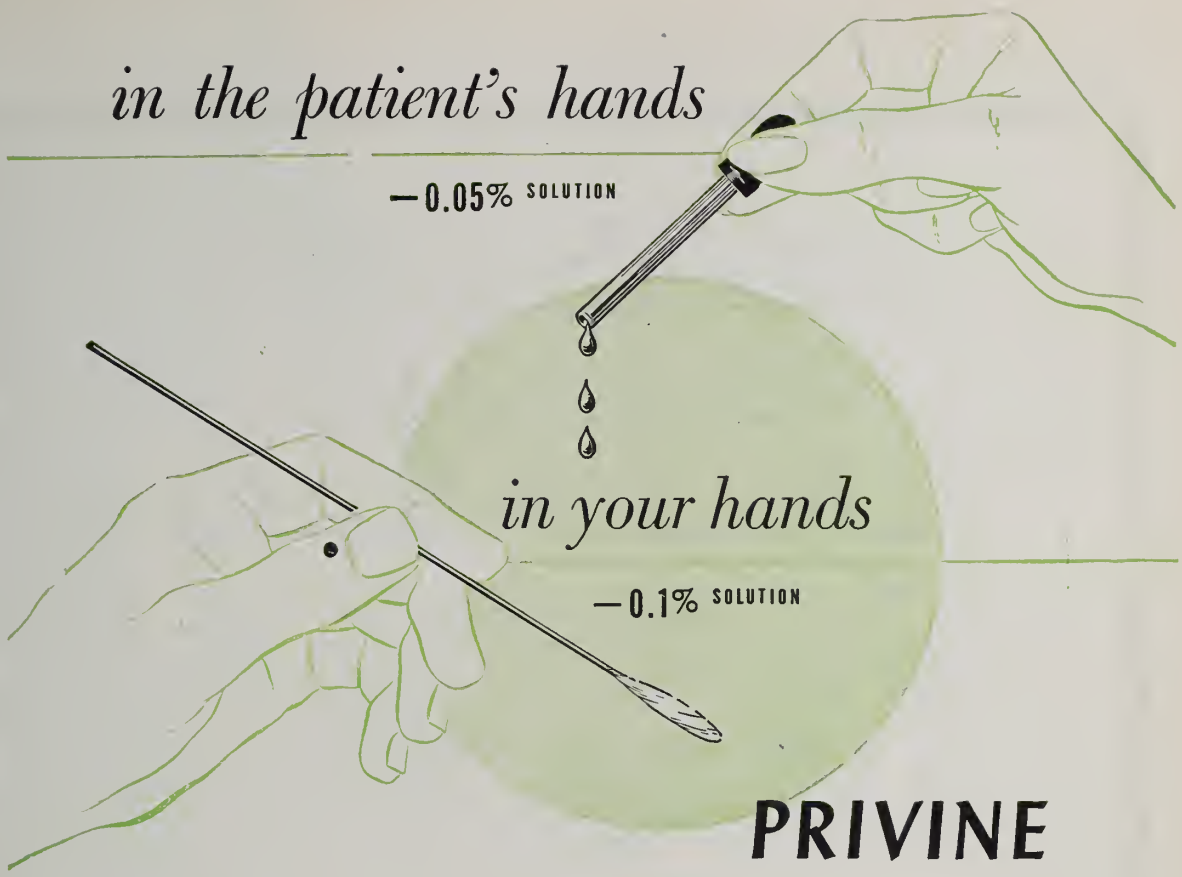
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No. 209 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



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But, of course, it is always better to *prevent* a serious illness whenever possible.

If you have a cold, it's just good sense to stay away from people, to avoid spreading the infection; and to get plenty of rest—in bed if possible.

If your cold is accompanied by fever, a persistent cough, or a pain in the chest, face, or ear, call your doctor at once.

The sooner you seek his help, the more he can do to help you avoid a long and serious illness.

And, in the case of children, an early examination may disclose that what appears to be only a cold may instead be a starting symptom of an entirely different disease, such as measles or scarlet fever.

SEE YOUR DOCTOR. Never try the foolhardy experiment of dosing yourself. Your doctor's treatment of one illness may be quite different from his treatment of another illness which appears the same to you.

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**Charles J. Marshall, New York Journal of Medicine, Vol. 34, Aug. 15, 1934*

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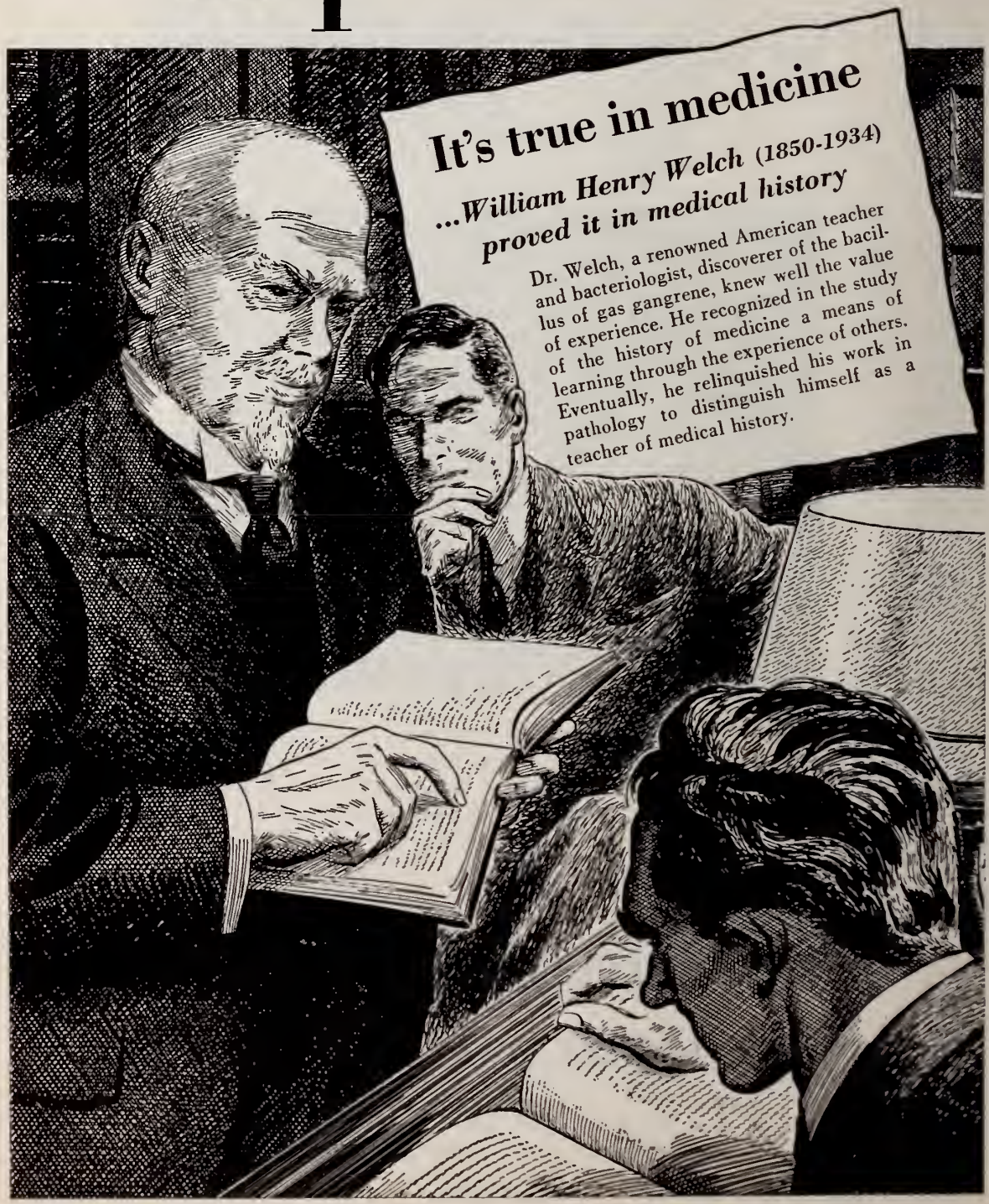
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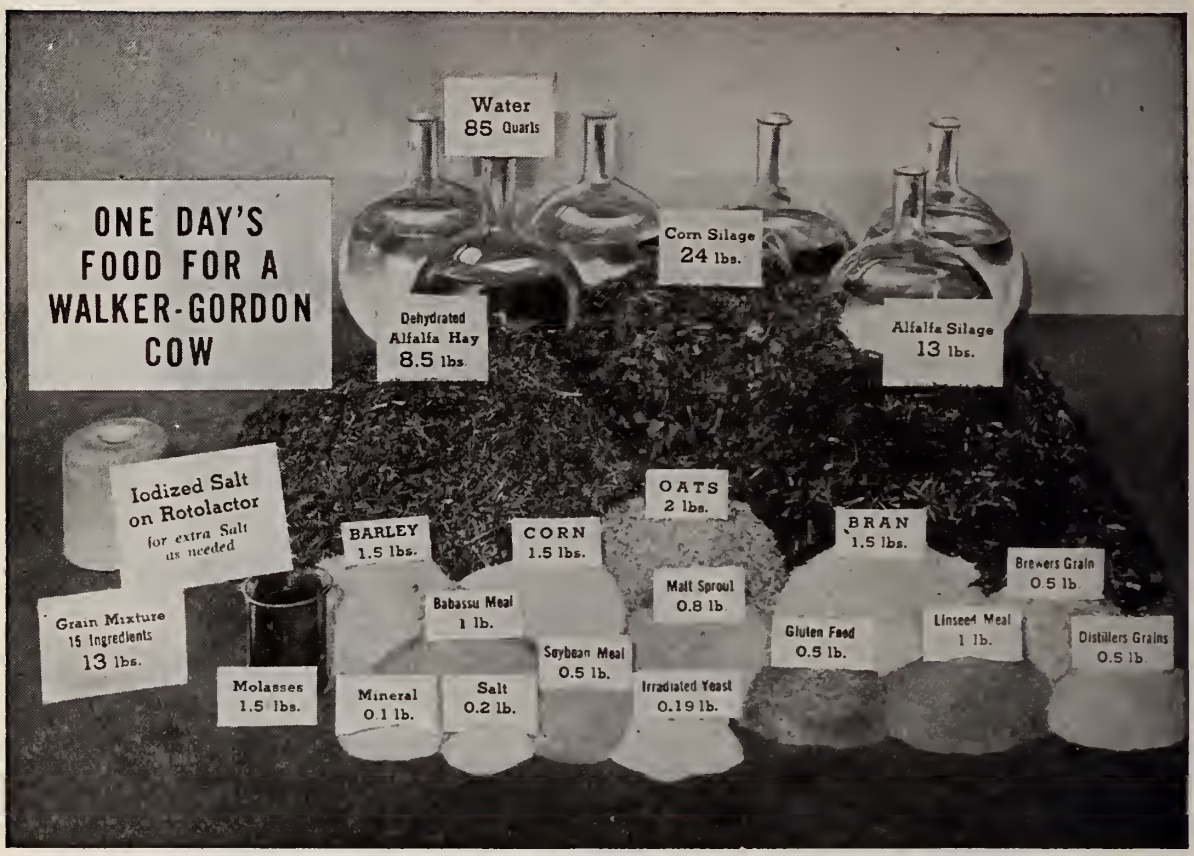
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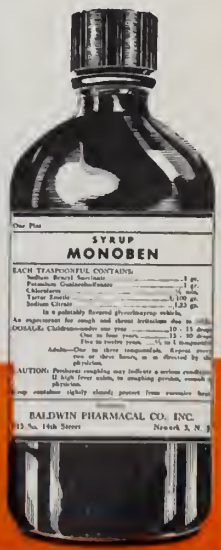
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THE PRESIDENT'S PAGE

THE FUNDS OF THE AMERICAN CANCER SOCIETY, NEW JERSEY DIVISION, INC.

The American Cancer Society, through its component state divisions and county chapters, raises several million dollars each year by its fund raising campaign. Sixty per cent of this money is allotted to the state divisions and to the county chapters by which it was collected, for use in local cancer control projects in the area concerned. Forty per cent is retained by the national organization for public education, research projects and administration.

The cancer control program includes three distinct activities: (1) An educational campaign to inform the general public of the early signs and symptoms of cancer and to encourage people to seek medical advice immediately upon the appearance of any of these signs or symptoms. (2) To underwrite widely scattered research projects throughout the country. (3) To expand existing resources and to develop new facilities for the diagnosis and treatment of cancer on a local level.

The Board of Trustees of the New Jersey Division have agreed to authorize the expenditure of funds for strictly medical projects in New Jersey only upon approval by the Cancer Control Committee of The Medical Society of New Jersey and the corresponding committees of our component county medical societies. It is, therefore, incumbent upon us that we carefully scrutinize all requests for funds by hospitals and clinics to insure that expenditures be made on an efficient and economical basis. Our Cancer Control Committee has passed upon and approved many projects which are being rapidly put into operation throughout the state. We have noted, however, that some of

the requests for funds are out of all proportion to the actual needs of certain hospitals and we have been obliged to disapprove those which seemed unreasonable, thus, in not a few instances incurring the displeasure of the group concerned.

We, in New Jersey, have not approved any project to establish a general diagnostic clinic because we believe that the funds of the Cancer Society should be expended only for the purpose for which the money was raised, namely, for direct action in the diagnosis and treatment of cancer. Patients should be admitted to the cancer clinic only after having been screened by their private physician or by a general medical clinic. In all patients admitted, there should be a reasonable possibility of the existence of cancer as indicated by at least one of the early symptoms or signs. We are not in disagreement with the idea of general diagnostic clinics *per se* and we thoroughly appreciate their value, but we believe that if established, they should not be solely at the expense of the Cancer Society, but should be subsidized by proportionate contributions made by other lay organizations such as The National Tuberculosis League, The American Diabetic Association and other groups. In a large number of patients examined in the so-called cancer detection clinics, only one in every 211 patients has been found to have a suspicious or actual cancerous lesion.

The strictest economy in the expenditure of Cancer Society Funds is essential because as yet we have had insufficient money with which to begin to undertake a solution of the tragic social and economic problem of the care of the terminal cancer patient.

We strongly urge all of our members to view the activities of our Cancer Control Committee with patience and understanding and with the knowledge that the approval by the Committee of any project is not contingent upon personal whim or favoritism towards any group or institution. Your wholehearted cooperation is earnestly solicited.

ROYAL A. SCHAAF, M.D.,
President,
The Medical Society of New Jersey.

FEDERAL GRANTS-IN-AID

On page 84 of this JOURNAL appears a report of the A.M.A. House of Delegates meeting in Cleveland, January 5 to 8, 1948.

This report is notable for several reasons, but we are moved particularly to comment upon the action taken by the House on a resolution referred to it by the New Jersey delegates recommending an important revision in the terms of the pending Taft-Smith-Ball-Donnell Bill, S-545. Our representatives proposed that federal grants-in-aid to the states for the purposes of the Act should be made available only to those states which could demonstrate conclusively a need for federal aid.

There is nothing new or astounding in this proposal. What does seem astounding to us is that the House of Delegates should refuse to adopt this recommendation. The New Jersey proposition is in harmony with the platform of the A.M.A. as adopted by the House of Delegates in 1944, Section D of which advocates "The allotment of such funds as the Congress may make available to any state *in actual need* for the prevention of disease, the promotion of health and the care of the sick *on proof of such need*." The italics are ours, but the words are those of the American Medical Association.

Furthermore there seems to be abundant circumstantial evidence that Sena-

tor Taft and others are sympathetic to confining federal largesse to those states that can show that they really need it.

And still furthermore, what is the sense of the entire scheme of grants-in-aid, if states amply able to finance their own social services are permitted to partake of the federal pudding?

The reason reported by the Reference Committee for its failure to support the New Jersey resolution was that it is "inexpedient", and "might alienate valuable political support at this time". The nature of this precarious "political support" is not specified, but we suggest that any political friendships that could be alienated by our insisting upon basic (and presumably agreed) principles is not worth the price of maintenance.

The possibility should not be ignored that we are letting the camel of socialized medicine at least half-way into our tent when we support even so mild a measure of federalized medicine as S-545. As Dr. Marjorie Shearon reminds us, "one has only to watch the progress of maternal and child health programs to be aware of bureaucratic pressure for more federal money and power once a grant-in-aid program is started".

Commenting specifically upon the New Jersey proposal to limit grants-in-aid solely to those states that can demonstrate a need for federal aid, Dr. Shearon asks:

"Does it do the 'rich' states any good to accept a federal hand-out? Of course not! They pay $1.50 to $2.00 for every federal dollar they get back. And with the hand-out they receive a sheaf of federal rules and regulations telling them how to spend their own money."

Regardless of the curious failure of the House of Delegates to support its own declared policy in this matter, the responsibility still rests with the Board of Trustees of the American Medical Association to take every reasonable action in support of this policy.

The consequences of any failure to maintain the principle that beneficiaries of grants-in-aid must prove the need for them, might well be disastrous. Grants-in-aid are not merely transfers of funds. They are bonds wherewith the grantor reduces the grantee to his whims and purposes. They may become the inadvertent web of nationalized medicine.

DR. HAWLEY HEADS VOLUNTARY HEALTH INSURANCE MOVEMENT

Dr. Paul R. Hawley has accepted appointment as chief executive officer of a new national organization representing a combination of the non-profit "Blue Cross hospital service plans and approved "Blue Shield" medical-surgical service plans.

Dr. Hawley, who resigned as chief medical director of the Veterans Administration on December 31, will assume his Blue Cross-Blue Shield duties on April 1, with headquarters in Chicago. He will take over executive responsibility for the nation's voluntary prepayment health care movement. Current estimated enrollment is 29 million in Blue Cross and 7 million in Blue Shield.

It is expected that Dr. Hawley, who distinguished himself in the reorganization of the medical and hospital program of the Veterans Administration, will soon dramatize the voluntary health insurance movement and make a major contribution to the development of these plans into a factor of first importance in the national medical care picture.

VOLVULUS OF THE SIGMOID COLON

REPORT OF FOUR CASES*

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Chief, Surgical Service, Veterans Administration Hospital, Lyons, N. J.
Charles M. Robbins, M.D.
Consultant Surgeon, Veterans Administration Hospital, Lyons, N. J.

While volvulus of the sigmoid colon is relatively infrequent in this country, in central and Eastern Europe, it constitutes 50 per cent of all intestinal obstructions.[1] The highest incidence in the United States is reported by Griffin, Bartron and Meyer,[2] as 8 per cent. This is calculated from 458 large bowel obstructions treated between 1937 and 1945 at Cook County Hospital. Actually these authors reduced this figure to 2.2 per cent based on the total of all types of intestinal obstruction treated in the same period.

Several explanations have been advanced for the high incidence of this type of obstruction in eastern Europe. In some of these countries a bulky vegetable diet, with or without constipation, as well as prolonged periods of fasting, followed by overeating, are believed to be essential factors. It is generally believed that fecal stasis and gaseous distention are the exciting factors causing large bowel volvulus. The distended gut rising in the abdomen with inadequate mesenteric fixation may twist through an arc that offers the least resistance. A redundant mesentery is the common denominator in the reported case findings. Whether this is primarily a congenital anomaly with secondary volvulus incidental to it, or whether progressive elongation and redundancy of bowel and mesentery develop after episodes of increased intraluminal stasis and pressure, or whether volvulus is the result of hyperperistalsis induced by catharsis, is not clear. Some information about this should be gained by observations in areas where a high incidence of this condition exists. In such localities it would be informative to determine statistically the dimensions of the sigmoid and its mesentery. If the so-called normal run of sigmoid colon and mesosigmoid examined in such countries is found more redundant and mobile, it would explain so high an incidence of sigmoid volvulus. If this were so, a congenitally, or acquired elongated sigmoid colon, with inadequate fixation on a lax and redundant mesentery, must be considered as a possible precursor to the development of a volvulus.

Volvulus of the sigmoid colon predominantly affects males. This may be due to their narrower pelves. Should they develop episodes of torsion, the obstruction could conceivably manifest itself earlier, with less chance of spontaneous release than in the wider female pelvis.

The four cases of sigmoid volvulus contained in this report constitute 2.3 per cent of all intestinal obstructions diagnosed in this hospital during the last eight years. In that period, no other type of true small or large bowel volvulus was encountered. Although sigmoid volvulus is found to be relatively infrequent it is not as rare as volvulus of the cecum. Brady[3] calculates that fewer than 300 cases of cecal volvulus had been reported in the literature.

Our cases were in adult male psychiatric patients, who were referred to the general surgical service from the neuropsychiatric units of the hospital. Two patients were regarded as being "indolent and lethargic". One was ambulatory and engaged in occupational and recreational activities. One patient had periods of hyperactive behavior. Pre-existing chronic constipation was not conspicuous in any of these patients. Their diets were well balanced, totalling about 3000 calories per day, with adequate proportions of carbohydrates, proteins and fat. Except for one underweight patient, the nutritional status of these subjects ap-

* Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed, or conclusions drawn by the authors.

1. Simon, H. E., Senturia, H. R., and Keller, T. B.: Am. J. Surg. 71:550 (April 1946).
2. Griffin, W. D., Bartron, G. R., and Meyer, K. A.: Surg., Gynec. and Obst. 81:287 (Sept. 1945).
3. Brady, J. H.: California and Western Medicine. 64:77 (Feb. 1946).

peared normal. A study of the charts of these patients did not reveal that catharsis was prominently exhibited at any time.

CASE ONE

A 51 year old man of Italian birth with negative family history had an attack of abdominal pain and vomiting in 1928, at the age of forty. He was then operated upon in another hospital through a left rectus incision. The type of procedure could not be ascertained. He had no previous history of operations, or of serious illnesses. Since then he had repeated episodes characterized by abdominal discomfort, moderate distention and occasional vomiting. In December 1938, gastrointestinal x-rays, including barium enema study, showed a filling defect along the greater curvature of the stomach and a large distended sigmoid colon displaced to the right. During this period it was found that he had arteriosclerotic heart disease, with cardiac enlargement, and a ventral hernia at the old operative site. Urine was negative. Stools for occult blood were negative. Proctosigmoidoscopic examination disclosed normal findings. Gastric analysis was free of blood and showed normal acid levels. In January 1939, during what appeared to be an asymptomatic period, an exploratory laparotomy under spinal anesthesia was performed through the old left lower rectus incision, with the intention of also repairing the ventral hernia.

On opening the abdomen, the large gut, including the sigmoid and descending colon, ballooned out of the wound. On further exposure, the sigmoid flexure was found rotated clockwise on its mesentery through an arc of about 180 degrees. This segment of bowel was mildly dusky and its mesentery was found redundant and formed the axis about which the bowel had turned. Examination of the mesentery after detorsion revealed areas of fibrosis at the root, probably indicative of previous torsions. Further exploration about the pyloric end of the stomach and above, revealed no abnormality. In view of the known myocardial impairment in this patient, a resection of the sigmoid, although preferable, was considered too hazardous at the time.

Following derotation of this segment of colon, gentle manipulation with a rectal tube in place succeeded in decompressing the gut. With interrupted catgut sutures the colon was then tacked down to the peritoneal gutter through the lateral peritoneal reflection of its mesentery. The abdominal hernia was repaired, utilizing a Catell type of fascial closure. This patient is known to be alive eight years after the operation, with no abdominal episode such as he previously experienced.

CASE TWO

A 57 year old white male of American birth, with negative family history, had a chancre in service, World War I. He received considerable specific therapy, which resulted in negative serology since 1931. Because of sudden abdominal pain and vomiting of several hours duration, he was admitted to the surgical service on June 14, 1946. The episode was associated with constipation of 36 hours duration. There had been no similar attacks previously. Temperature was 99, pulse 68, respirations 22, and nutrition poor. The abdomen was moderately distended. Tenderness was elicited over the abdomen, notably in the right upper quadrant. The abdomen was tympanitic throughout and it was held intermittently tense, apparently with cramp-like pains. Peristaltic sounds were exaggerated, but not particularly violent. The rectal ampulla was felt to be dilated. Urine showed no significant changes. Warm tap water enemas produced some fecal matter, but patient could only retain about a pint at a time. The return with the third pint was clear, following which a rectal tube was inserted. Vomiting ceased and within twelve hours the patient was free of discomfort. Subsequent x-ray studies showed normal visualization of the gall bladder and an elongated and markedly dilated sigmoid colon. A diagnosis of chronic recurrent volvulus of the sigmoid was made.

In his subsequent course, his abdomen appeared normal. There were no subjective complaints and bowel movements were normal. Stool examinations were negative for occult blood. Proctoscopic examination revealed no abnormal findings. Because of the two previous episodes of obstruction and on the basis of x-ray findings, it was decided to perform an exploratory laparotomy during the interim period. On October 3, 1946, laparotomy under spinal anesthesia revealed a markedly redundant, thick, but only moderately distended sigmoid colon, in a position of partial rotation clockwise. There was no unusual change of color of the colon, but the base of the mesentery contained fibrotic patches. In the absence of frank manifestations of obstruction, a primary resection of 21 centimeters of redundant sigmoid was performed, the ends closed, and continuity established with a side to side anastomosis. *Pathologic report*: Specimen received in fixative is a portion of large bowel. The serosal surface is smooth and glistening. The muscularis and mucosa present no abnormalities. Attached to the bowel is mesentery four centimeters at its greatest width, with areas of thickening of the mesentery near the line of resection. Microscopic examination showed no abnormality other than moderate congestion of the serosal vessels.

CASE THREE

Our next patient was a 54 year old white man of American birth. There is nothing relevant in his medical history, except that in the past two years he would have sudden episodes of constipation, when his abdomen would "blow up". He would then feel uncomfortable for a few hours. The episode would subside as suddenly as it developed. He took cathartics infrequently, usually in the form of salts, which gave him relief during such episodes. On October 10, 1946, he was admitted to the surgical service with a history of nausea for several days and vomiting twice in the past twelve hours. During this period he had also been constipated. The stools were described as being "quite light".

The abdomen was soft, except at and under the right costal margin, which was spastic and tender. Palpation of this region also outlined a circumscribed, moderately tender mass, which was felt

to be the gall bladder. The liver edge could not be felt. In addition there could be distinguished an area of tympany and a soft elastic mass below the liver, mesially about the level of the umbilicus. Rectal examination was negative. Urine showed only a faint trace of albumen. Specific gravity was 1.015. Icteric index was 7. X-ray studies of the gall bladder, gastrointestinal tract, and barium enema were made. The gall bladder was not visualized. Gastrointestinal and barium enema studies disclosed distention and redundancy of the descending colon and sigmoid. With persistence of signs localized in the right upper quadrant and temperature ranges to 101, with elevated pulse, the patient was preoperatively prepared for gall bladder surgery and a laparotomy was performed on October 30, 1946, through a long right upper rectus muscle splitting incision.

In the exploratory phase of the operation an enlarged gall bladder, with numerous concretions and adhesions, was found. In addition, a distended loop of large bowel was encountered, which was clearly defined as sigmoid colon, twisted counter clockwise and to the right through an arc of about 180 degrees. It was this soft, elastic mass that had been felt through the abdominal wall below the palpable fundus of the gall bladder. The bowel segment appeared to be in good condition. Following detorsion and manual compression the bowel rapidly deflated. Its mesentery was found elongated and contained areas of fibrosis. Since this patient's manifestations were referable to the gall bladder, the latter alone was removed, with the expectation of correcting the redundant sigmoid colon at a later date. Pathologic study of the gall bladder reported that the organ measured 16 centimeters from neck to fundus, and was 8 centimeters wide at the fundus. The mucosal surface was irregular and injected. The wall was two millimeters thick. About 50 concretions averaging four millimeters in diameter were present. A pathologic diagnosis of chronic cholecystitis, with cholelithiasis, was made.

CASE FOUR

A 58 year old white man of American birth and negative past history was admitted to the surgical service on November 7, 1946, complaining of upper abdominal pain, without radiation, of about three hours' duration. The pain came on suddenly. It was sharp and persistent. He had vomited twice, the vomitus being characterized as "coffee-ground". No history of constipation was obtained. The patient complained that he had no bowel movement and had not passed flatus in about 24 hours, although he had an urge to defecate.

The abdomen was distended. Peristaltic sounds were audible and there was suggestion of rebound tenderness. Rectal examination was negative. Flat film of the abdomen showed diffuse large bowel distention as far as the ascending colon. Exploratory laparotomy was performed on the morning of admission. A darkened, distended, sigmoid loop was found with a constricting band about the sigmoid. This band was severed, resulting in deflation of the bowel, following which the patient made an uneventful operative recovery.

On January 19, 1947, the patient had another sudden episode of vomiting and abdominal distention associated with little abdominal pain. There was no rigidity, and no interference with the passing of some flatus and stool. He did not seem to be in distinct distress. He was able to hold a quart of soapsuds enema, which was productive of formed stool, and following introduction of the rectal tube his abdomen became soft and relatively flat within 24 hours. An interim barium study showed an enlarged sigmoid colon suggesting the possibility of volvulus formation. On the morning of February 5, 1947, he again developed abdominal distention, diffuse abdominal pain and vomiting. He appeared acutely ill. Temperature was 101.4, pulse 100, respiration 24. Percussion note over the abdomen was tympanitic, with loud peristaltic rushes on auscultation. Tenderness was diffuse. Rectally it was felt that the ampulla was dilated. The white cell count was 14,800 with 86 per cent polymorphonuclears. Urine was negative.

On the same date an exploratory laparotomy through a left lower rectus incision was performed under spinal anesthesia. A markedly elongated and distended sigmoid (several times its normal diameter) was found twisted clockwise on its mesentery and exceeding a turn of 360 degrees. Three ounces of clear fluid were found in the peritoneal cavity. The mesentery was ecchymotic, with evidences of hemorrhagic infarcts. The involved twisted segment of bowel consisting of the greater part of the sigmoid flexure was discolored. The distention was extreme, extending proximally to the transverse colon, and to a lesser extent to the ascending colon. The small bowel was of normal size. On derotating the sigmoid loop, there was some spontaneous deflation. Because of the existence of such recent obstruction, an obstructive type of resection was performed, removing 55 centimeters of redundant sigmoid bowel. The spur was subsequently crushed and the colostomy stoma closed. The patient has been notably free of any abdominal complaints.

The specimen consisted of resected large bowel. Its serosal surface was dull, with numerous dark red and purple areas. In places the color was mottled purple black. The mucosal surface was rough and granular and presented a markedly discolored, mottled, dark grey-green, red and purplish appearance, with areas almost black. The entire wall was edematous. The mesentery was thickened. Microscopic examination revealed infarction and gangrene of the bowel.

SUMMARY AND CONCLUSIONS

Four cases of volvulus of the sigmoid are reported. The subjective manifestations were found to vary with the degree of torsion and with the rapidity of onset. Reviewing the clinical types that may be encountered, it is found that in the acute type distention develops rapidly, with vomiting, abdominal pain, diffuse tenderness, and exaggerated peristaltic

sounds and even prostration. This may be difficult to differentiate from a perforated viscus, or any other surgical abdominal crisis. It, therefore, demands early exploration. In the sub-acute type, with incomplete torsion, the obstruction will be incomplete, and the symptomatology may be minimal to moderate. This constitutes the most frequent type of volvulus obstruction of this segment of bowel. Here the patient may be ambulant, with little abdominal tenderness, some constipation, with or without tenesmus, despite considerable abdominal distention. Common to both types is the finding that although the bowel may spontaneously untwist itself, attacks of volvulus are prone to recur until an episode may arise when obstruction become complete and prolonged with all of its grave sequelae.

Whatever the immediate cause, the underlying pathologic anatomy predisposing to, (or acting as an essential prerequisite for) the occurrence of a volvulus, is the finding of an elongated sigmoid loop, with a redundant sigmoid mesentery. Scars of the mesentery are commonly found as evidence of previous mesenteric twists. Operative findings also disclose that even during a quiet, or seemingly asymptomatic period, the sigmoid colon is dilated and some degree of torsion is present. All of our patients were in the sixth decade of life. In all cases except one, torsion was clockwise.

The treatment is operative correction. If operation is performed during an obstructive, quiescent period, resection with primary anastomosis is feasible. During the actual obstructive phase, an obstructive-resection may preferably be performed with immediate, or early "venting" of the proximal loop. The statistical mortality of this type of obstruction is high and has been variously reported up to 40 per cent. This indicates the need for its earlier recognition and the application of those operative principles and therapeutic measures employed in general in mechanical obstruction of the bowel.

Veterans Hospital, Lyons, N. J.

WHAT IS BAGASSOSIS?

A new disease of the lungs, called "bagassosis," which resembles acute bronchitis and pneumonia, is proving a serious industrial hazard in sugar producing areas, according to an article in *Radiology*.*

Bagasse is sugar cane after it has been crushed and the juice has been extracted. The pulmonary disease, caused by inhalation of dried bagasse dust, is a rare disease, the medical literature listing only thirty or forty cases.

Terming the disease "a serious industrial hazard," the authors say that it has been restricted somewhat to "the communities which grow sugar cane and process it into sugar, such as Louisiana, or to cities where the bagasse is manufactured into building board, as in England, or where it is used in making refractory brick, as in Missouri. Bagassosis also occurs in men employed in the Cuban sugar industry, where much dust is produced in handling sugar cane at the time it is cut."

Patients with long exposures become critically ill. Two investigators collected twenty-four cases, reporting two deaths, a mortality rate of 8.3 per cent which "is sufficiently high to indicate that this is an industrial disease of a serious nature".

Persons with only moderate or short exposure to the dust in light concentrations contract a less severe form of the disease, which usually clears up in two to six months.

About two months of exposure to the dust are required before symptoms appear. These symptoms include fever, shortness of breath, cough, and weakness. Onset is insidious. The patients do not know they are ill until seized by a sudden coughing spell and weakness.

Sulfa drugs and penicillin have been of no help, but oxygen afforded some relief. Whether the reaction is due to fungi, bacteria, or a virus associated with the dust, or to an allergic response to the bagasse or its possible infectious agents or their products, or to some chemical or physical property of the dust, has not been determined. Because of the industrial importance of the properties of bagasse, its use will extend to other purposes. It is already being used in the manufacture of acoustical and thermal insulating building boards and materials. It can be anticipated that the incidence of bagasse disease of the lung will increase.

* By D. V. Lemone, W. G. Scott, S. H. Moore, and A. L. Koven

TREATMENT OF CORONARY THROMBOSIS *

Henry C. Crossfield, M.D., East Orange, N. J.

Review of the literature of the past few years on the treatment of coronary thrombosis reveals that there has been far less published, (except on the subject of anticoagulants) than the importance of the subject warrants. Perhaps this is explained by the feeling of inadequacy that most cardiologists, including myself, have toward their system of treatment.

I would like to consider our present methods of treatment in order to emphasize the more recent advances with the hope of delivering more live patients back to their families at the end of the shortest time possible with the greatest cardiac reserve possible. It is, of course, of prime importance to preserve the life of the patient. But in most cases, it is also important to preserve adequate cardiac reserve for earning a livelihood after the acute illness is over. This should not be forgotten in our haste to get the patient back to work.

IMMEDIATE TREATMENT

1. *Opiates:—Morphine or dilaudid.* Give the latter if nausea or vomiting is present. Use either intravenously if the pain is very severe giving less than the usual subcutaneous dose, depending on the blood pressure and severity of pain. Atropin sulfate, grain 1/75 is given also, especially when the heart rate is not rapid.

2. *Aminophyllin intravenously 3¾ grain.* If pain persists, this may be repeated three or four times in 24 hours.

3. *Papaverine intravenously grain ½ to 1,* especially if the heart tends to be irregular.

4. *Oxygen*—60 to 80 per cent for the relief of pain, dyspnea or shock. Intranasally with Tudor Edward spectacles or B.L.B. mask, this gives the highest oxygen concentration. If a tent is used, the oxygen flow should never be below 10 to 12 liters per minute.

5. *Quinidin sulfate, grains 3,* two or three times a day, (except in old fibrillators or in patients with heart block) is perhaps one of the best insurances against sudden death from ventricular fibrillation.

6. *Oubain or strophanthin.* If the patient is decompensating and is not partly digitalized, one cubic centimeter intravenously (1/250 grain) should be given. Digitalis should not be used, but if it is, lanatoside C or cedilanid is preferable, two to four cubic centimeters intravenously if the patient is not already partly digitalized. Less than a full digitalizing dose is recommended to avoid the vagal effect.

7. *Bleeding* may be advisable if the patient is moribund with right heart failure. Follow this with an infusion of five per cent glucose in distilled water at about 30 drops per minute.

PROTRACTED TREATMENT

Protracted treatment is given after the acute phase of pain is over.

1. *Psychic rest* — The doctor should be slightly more optimistic to the patient than the condition warrants, provided the patient cooperates with physical rest. If he does not cooperate, it is sometimes necessary to point out the dangers of incomplete cooperation. No other point of dissension should be allowed in the sick room during the first month. On all other subjects, it is better to agree with the patient if at all possible.

2. *Physical rest*—To obtain the greatest cardiac reserve after the acute phase is over, I am a persistent advocate of a thorough rest treatment. Willius [1] has stated "The present era of medicine invites dramatic and spectacular developments; but it is extremely important that the basic facts of physiology and pathology should not be over-looked and that accelerated methods of management, which are contradictory to these basic facts, should not be introduced". If we are to know how complete and how long the rest should be, we should know the pathology and the rate of healing. White and Patmos (cited by Willius [1]) a few years ago, stated that after nine days the areas of necrosis were diminished and after 22 days, regions of diffuse fibrosis were present. In infarcts from three to six months old, condensation and contraction of the fibrous scar were present and represented

* Read by invitation to the Section on Medicine, Academy of Medicine of Northern New Jersey, October 23, 1947.

complete healing. Mallory [2] and his coworkers confirmed this and concluded "small infarcts are almost completely healed after five weeks and large ones after two months".

It has been my observation (as well as that of many others, though no figures are available) that patients who have the most complete rest during the first few weeks obtain the greatest cardiac reserve for after-life.

The patient may be turned from side to side and his head should be elevated if he is decompensated. Willius [1] has had the patients' legs massaged twice a day for the past twenty years. Ordinarily, patients should be rolled on and off the bedpan, but the commode may be used by some of the less seriously ill if assistance is given when he rises from the bed. Movement of the legs and arms should be encouraged; but the patient should not raise his body up from the bed alone, since this changes intrathoracic pressure, and any change in that pressure might cause a further vascular accident.

3. *Sedatives*—A mild sedative should be given frequently, but not in large dosage. Any dose in excess of three grains of barbiturates will reduce the oxygen-carrying capacity of the blood.[3]

4. *Diet.* Restricted or low caloric diet promotes a more rapid recovery. In general, we allow 800 to 1200 calories a day, the aim being to permit no more than half the patient's usual caloric intake.

5. *Bowel regulation.* No laxatives should be given during the first two days. Indeed, Hoskins [4] advises against them for four days. The patient may use a tablespoonful of mineral oil daily because there should be no straining at stool. Glycerine suppositories, cascara (one or two grains) or a very small enema may be used if necessary.

6. *Tobacco and alcohol.* The general rule is no tobacco and very little alcohol.

7. *Anticoagulant therapy.* Heparin, 50 milligrams, should be given intravenously, immediately and every four hours until the prothrombin time has been effectively lowered. This is done by giving dicumarol. Dicumarol is administered in 300 milligram dosage the first day after determining that the prothrombin time is not already above normal. The prothrombin time should be determined no less than three hours after the last dose of heparin. Daily determinations should be made thereafter by the modified Quick method. Be prepared to give fresh citrated blood at any time if there is evidence of hemorrhage; but 60 milligrams of synthetic vitamin K, given intravenously, sometimes is sufficient without a transfusion.[8] This may be repeated in two hours, if needed. If bleeding occurs, it most often comes from the kidneys or the gastrointestinal tract. Occasionally ecchymotic hemorrhage occurs or there may be minor nose bleeds. Seldom is there significant hemorrhage when the prothrombin is more than 10 per cent. By the Mayo technic, that would be equivalent to less than 58 seconds prothrombin time. Allen [8] also states that thrombosis seldom occurs when the prothrombin is less than 30 per cent (more than 27 seconds prothrombin time). After the first 300 milligrams have been given, 100 milligrams are administered on those days when the prothrombin time is 20 to 35 seconds, none if the prothrombin time is more than 35 seconds, and 200 milligrams if it is less than 20 seconds. This is varied with the size of the patient and with the probable condition of the liver and kidneys. If the function of those organs is poor, less dicumarol is needed. This program should be continued for three to four weeks and probably longer in many cases. In the latter part of the treatment, the prothrombin proportion should not be kept too low as it is not considered necessary. Fifty milligrams of dicumarol per day have been used in a few ambulatory patients. If it is necessary to omit dicumarol in coronary thrombosis, one may use the concentrated heparin, 100 milligrams per cubic centimeter. Doses of 50 to 150 milligrams are usually given every twelve hours, intramuscularly, according to the method of Stats and Neuhof.[9] Coagulation times, (Lee and White technic) should be performed daily for this method, but if the 50 milligram dose every four hours is used, no laboratory tests are considered necessary. A satisfactory prolongation of the coagulation time is 18 to 24 minutes.

BACKGROUND OF ANTICOAGULANT THERAPY

Hemorrhagic disease in cattle, caused by eating spoiled sweet clover, has been known for a quarter of a century. However, not until 1940 did Link and his co-workers isolate and synthesize the "prothrombin-lowering-principle" that caused this bleeding.

It has been my good fortune to have had dicumarol available for use in thrombotic disease since December 1941, due to the courtesy of Dr. Irving S. Wright. This was only a few months after Allen and his colleagues had described its experimental use in human beings. Since 1941 one might suppose that we would have collected a large series of dicumarol-treated cases, but unfortunately that is not true. Until recently we were using it only in peripheral vascular lesions and more recently in coronary cases with a previous thrombosis or in extreme cases. That was partly due to the expense of daily prothrombin determination and partly due to the fact that we thought we could get along without it in the milder cases. Recently, the conviction has developed that, despite the financial burden, practically all patients should have it. Some hospitals have been asked by the Committee on Anticoagulant Therapy of the American Heart Association (headed by Dr. Wright) to use it routinely on every other case of coronary thrombosis. Later, the results will be published. So far nothing official has been issued, but it is generally conceded that results are better in those receiving anticoagulant therapy. The first report on the use of dicumarol in the treatment of a group of cases of coronary thrombosis was made by Wright[5] in 1945. There had been an occasional case treated with it as far back at 1941. Perhaps the first article that drew much attention was that of Nichols and Page[6] in January 1946, describing results in 50 cases. They reported a mortality of only 12½ per cent among patients who had received dicumarol. The following month, Peters[7] reported on 110 cases of coronary thrombosis. Their mortality was 4 per cent in the group that had received anticoagulant therapy and 20 per cent among the patients who had not had this form of treatment. The ratios of clinical embolism were likewise striking: 2 per cent in the anticoagulant-treated group and 16 per cent in the other. These figures are so markedly favorable to the use of anticoagulants that the American Heart Association decided to try it on a large scale in many hospitals.

CAUSE OF DEATH

Though it is not definitely known, it is generally believed that the most common causes of sudden death in coronary thrombosis are (1) extension of the thrombosis backwards, or (2) mural thrombi which give rise to emboli or (3) ventricular fibrillation. The anti-coagulants seem the best answer to the first two, and quinidin to the third. But nothing we now know will save 100 per cent of these cases.

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STREPTOMYCIN AND THE GONOCOCCUS

Eight newly isolated strains of N. gonorrhoeae were tested for sensitivity to streptomycin in vitro by the agar dilution streak method. Since it has been found that 2 mg. of glucose in 10 ml. of medium will reduce the potency of streptomycin by one-half, two parallel series of tests were performed, in one of which glucose and salt were omitted from the medium. All the strains of N. gonorrhoeae used were identified by the oxidase reaction, staining, and cultural characteristics. The first medium employed was "Bacto" proteose peptone No. 3 agar, enriched with 20 per cent citrated horse blood partially laked by the addition of one-third volume of sterile distilled water. The parallel series was run on a second medium which differed from the first in that glucose, sodium chloride, and disodium phosphate were omitted. The plates were streaked from 24- to 48-hour cultures, and examined at 24 and 48 hours.

The results, presented in table form, show that when the original proteose peptone No. 3 medium was used, the strains of N. gonorrhoeae were totally inhibited by 10 units of streptomycin per cubic centimeter of medium in 13 of the 16 tests performed, and in all instances by 15 units. In the sugar-and-salt-free medium, however, the streptomycin was more active, and complete inhibition was obtained with a concentration of 5 units per milliliter of medium in 6 out of 10 tests, and occasionally with 1 unit. No appreciable difference in sensitivity among the strains was observed.

—Mortara, D., and Saito, M., in *Journal of Venereal Disease Information*, 27:152.

CONSERVATIVE USE OF THE GASTROSCOPE *

THEODORE S. HEINEKEN, M.D., Bloomfield, N. J.

At the Army and Navy General Hospital, Hot Springs, Arkansas, one hundred patients were studied conservatively by means of the gastroscope in order to aid in the diagnosis of gastric disease.

When a satisfactory diagnosis by the roentgenologist has been made and when there is no doubt as to diagnosis, the use of the gastroscope is unwarranted. Many times, however, x-ray diagnosis will be negative while the patient continues to exhibit gastro-intestinal symptoms. Or, a lesion may be found roentgenologically, which cannot be clearly recognized without direct visualization.

My examinations were limited to the study of a selected group of patients who (1) had negative x-ray findings with continued gastro-intestinal symptoms; or (2) who had achlorhydria by the histamine test; or (3) had doubtful gastric lesions.

MATERIAL

The hundred cases reported consisted of 45 veterans of World War I, 9 veterans of War II and 46 regular army personnel. A total of 112 examinations were made in a period of eighteen months. Most of the veterans of World War I were from the southern states and had exhibited no gastro-intestinal symptoms while in the army. The veterans of World War II on the other hand, had had gastro-intestinal symptoms, and indeed had been discharged from the service because of them. All the regular army personnel were admitted to the hospital because of gastro-intestinal symptoms.

Our primary interest was to determine if there were pathologic lesions of the stomach not seen by x-ray or to aid the roentgenologist in a diagnosis. Thirty-six per cent of the cases were normal; 33 per cent showed chronic nonspecific gastritis; 11 per cent showed gastric ulcer; 2 per cent had gastric carcinoma, and one had gastric syphilis. The others were distributed among other lesions as seen in the table.

GASTRIC ULCER

Eleven cases of gastric ulcer were visualized with the gastroscope. These were corroborated roentgenologically in only three instances. Two cases were diagnosed by x-ray as gastric ulcer, but were not demonstrated gastroscopically. The ulcer in the first case was located on the posterior surface and could not be observed because of the blind area or trough. The second case was diagnosed by the roentgenologist as "gastric ulcer or thickened fold at the angulus". With the gastroscope, the thickened fold was found with only a hypertrophic gastritis present. In another case, a diagnosis of carcinomatous infiltration was made by x-ray at a station hospital, but gastric ulcer was found at the angulus by aid of the gastroscope.

He was a 32-year-old soldier who had had, at frequent intervals, epigastric distress and pain two to three hours after meals, relieved by food and alkalies for the past two and a half years. He had sustained weight loss of fifteen pounds during the past two months, and at one time, had black tarry stools. At the station hospital he was not relieved by diet and medication and continued to lose weight. Free hydrochloric acid was 34 per cent and x-ray findings showed a constant narrowing at the distal end of the stomach (prepyloric region), over which peristolic waves did not pass. This area was not fixed in relation to other structures. There was no retention in six hours.

GASTROSCOPIC FINDINGS

	W.W.I	W.W.II	RA	Total
Normal	14	6	16	36
Mucosal hemorrhage and anemia	2	.	3	5
Gastric ulcer	4	1	6	11
Chronic nonspecific gastritis	15	2	16	33
a. superficial	(1)	.	(5)	
b. atrophic	(5)	.	(1)	
c. hypertrophic	(9)	(2)	(10)	
Gastric syphilis	..	.	1	1
Benign tumors	..	.	2	2
Gastric carcinoma	2	.	.	2
Post-operative stomach (gastritis)	6	.	1	7
Examinations made but not satisfactory	2	.	1	3
TOTAL	45	9	46	100

* From the Gastro-Intestinal Clinic, Mountainside Hospital, Montclair, New Jersey. Formerly chief of gastroenterology, Army and Navy General Hospital, Hot Springs, Arkansas.

X-ray impression was angular infiltrating lesion in the distal end of the stomach, suggesting carcinoma. On admission to Army and Navy General Hospital he still complained of belching and distress with pain after meals, relieved with alkalies and diet. Gastroscopic examination disclosed a small ulcer on the lesser curvature at the angulus, about one and half centimeters in diameter, with a red inflamed edge. About this ulcer on the lesser curvature and on the posterior surface was also seen an area of chronic hypertrophic gastritis. Repeated gastroscopic examination one month later (after treatment) showed the ulcer to be pin point size with a small inflamed edge. The patient gained eleven pounds after treatment and was entirely free of pain.

GASTRITIS

Thirty-three per cent of the series revealed chronic nonspecific gastritis, equally divided between veterans and members of the regular army. The superficial type was predominant in the regular army personnel while the atrophic type was seen in veterans of World War I. Only one atrophic gastritis was observed in a regular army soldier, and he had a proved pernicious anemia. Twenty-one cases of chronic hypertrophic gastritis were found. These findings were based on the discovery of numerous verrucous elevations in the gastric mucosa, beading or cobblestone appearance of the rugae, and dulness or diminished highlights in the mucosa. Crevices and red inflamed areas of the crests of the rugae were also encountered with hemorrhagic areas. The x-ray diagnosis of severe hypertrophic gastritis was difficult but our roentgenologist was accurate in about one third of the cases. His interpretation of this condition was based upon thickened rugal markings and disruption of the mucosal pattern.

GASTRIC CARCINOMA

Two cases of carcinoma of the stomach were found. The first was found to have a lesion in the pylorus by x-ray, "suggestive of carcinoma". Gastroscope examination disclosed a malignant lesion, infiltrating into the antrum. This was subsequently demonstrated at operation and verified by pathologic report. In the second case, no x-rays were taken because this patient had been vomiting for two weeks and by physical examination, the clinician suspected a lesion at the pylorus. Gastroscopically a polypoid carcinoma was seen in the antrum involving the lesser curvature. Our findings were verified by operation and pathologic report.

BENIGN LESIONS

Two cases with benign lesions were demonstrated. Both exhibited normal gastro-intestinal x-ray series. The first patient had had frequent bouts of dull pains in the left upper quadrant with occasional belching, nausea and distress after meals. After five polyps were observed gastroscopically in the fundus of the stomach a repeated x-ray series was done and the lesions were demonstrated. The second patient complained of weight loss, with belching and distress after meals. He had been gastroscoped previously and a flat polyp seen on the lesser curvature and one on the greater curvature in depth two. A diagnosis of atrophic gastritis had also been made. Gastroscopic examination revealed a wart-like polyp on the lesser curvature in depth two, but the polyp on the posterior wall could not be found. Atrophic gastritis was also present.

GASTRIC SYPHILIS

Of particular interest was the syphilitic lesion found in one patient.

He was a 26-year-old soldier complaining of pain in the left upper quadrant. The pain usually began two hours after meals, radiating to the left anterior chest accompanied with nausea, vomiting and considerable belching. During the intermission of the sharp pain he had a constant dull pain in the left upper quadrant. This was relieved with diet but not with alkalies. His other complaints were headaches and general nervousness. Gastro-intestinal and gall bladder series were negative. His gastric analysis (Ewald) showed nine per cent free hydrochloric acid, histamine test meal 19.3 per cent free HCL. Stools were positive for occult blood. He had not responded to a strict diet and alkalies, and was gradually losing weight: twenty pounds in two months. On transfer to Army and Navy General Hospital, a further history revealed that he had, on one occasion while on leave, become drunk and could not recall what had happened after that. He denied any penile lesion or rash. Physical examination was negative except for tenderness in the left upper quadrant and around the umbilicus. Gastroscopic examination was done before laboratory findings had been completed. A superficial gastric ulcer, hard and smooth

with a white base, of triangular shape (measuring two centimeters at the base and three centimeters in length) was seen on the lesser curvature, proximal to the angulus. Kahn and Wassermann were positive. Gastric analysis with histamine was 12 per cent free HCL in one hour. Ten days later repeated Kahn and Wassermann were positive. Fractional gastric analysis with histamine two weeks later revealed no free hydrochloric acid in one hour. He was given three injections of mapharsen in ten days and re-gastroscoped. The ulcer previously seen had decreased in size and was now only three millimeters in diameter. A small area of hypertrophic gastritis was present in depth one on the posterior surface, which had not been seen before. His last gastric analysis after treatment showed 50 per cent free HCL with histamine. He became symptom free and regained his weight with anti-syphilitic treatment. As Eusterman says: "Syphilis is the most frequent and most important specific granuloma of the stomach. An acidity with positive serology and good results with specific treatment are considered decisive clinical features. With a syphilitic ulcer, the floor is hard and smooth. It may be small or very large. After treatment it will disappear completely."

EXAMINATION AFTER DEATH

I performed a gastroscopic examination on one patient who had expired an hour earlier. It was our desire to know, before autopsy, if the malignancy (present in the lung and liver) was secondary to a gastric lesion. The patient's condition before death was too critical for him to be gastroscoped. Gastroscopic examination failed to disclose any primary lesion in the stomach. The gastroenterostomy stoma was present and the mucous membrane revealed dark blood between the folds which were attributed to postmortem changes. The mucosal folds were thickened as one would see with a chronic post-operative gastritis. No carcinoma was found gastroscopically nor at post mortem.

PSYCHONEUROSIS

Psychoneurosis was present much more commonly in patients with normal gastric mucosa than in those with organic findings. It was impossible to give an accurate figure because most of these cases were either quickly returned to duty or transferred to the psychiatric section. A. W. Annis * states: "Let us not say that gastritis has little or no significance, since the symptoms of dyspepsia depend largely on the functional rather than the organic changes; in fact, it seems logical to assume that any anatomic change operates merely as a stimulus or trigger mechanism which unleashes the ensuing barrage of functional disorder."

CONCLUSIONS

Gastroscopic studies have been made on one hundred veterans of both World Wars and on regular army personnel. From these studies, I draw the following deductions.

1. Gastroscopy is diagnostically helpful in the military service.

2. It aids the roentgenologist in the study of gastric disease, but does not replace the x-ray.

3. In the study of chronic non-specific gastritis, the gastroscope is invaluable. Changes in the gastric mucosa can be studied more carefully gastroscopically than by any other procedure.

4. It is of real value in the diagnosis of gastric ulcer and in syphilitic lesions of the mucosae. It has limited value, however, in the diagnosis of lesions on the lesser curvature, prepyloric region and posterior surface near the cardia.

5. The diagnosis of carcinoma, especially in early stage is facilitated by gastroscopy.

6. Gastroscopic equipment and trained personnel are desirable in every large Army, Navy and Veteran's Hospital.

17 Park Place

CAMP DOCTOR NEEDED

Watchung Area Council of the Boy Scouts needs a doctor for its summer camp. Any interested physician should communicate with the Executive Offices of the Society in Trenton.

* Annis, J. W.: *Gastroenterology*. 2:120, February 1944.

RECENT ADVANCES IN GYNECOLOGY *

Mortimer H. Weiss, M.D., Newark, N. J.

A kaleidoscope of recent advances in gynecology is displayed in Meigs and Sturgis' *Progress in Gynecology*. Thus, E. L. Lozner, shows that menstrual blood normally clots within the uterus and that the clots are therein digested. The bloody fluid issuing from the cervix as menstrual discharge does not clot because it lacks prothrombin and fibrinogen, removed in the antecedent clotting mechanism. Since this is a purely local phenomenon, operating within the uterus, the circulating blood is unchanged during menstruation, which should therefore not be considered a contra-indication to the performance of necessary surgery during a menstrual period.

Louis K. Diamond makes the interesting observation that 40 per cent of Rh negative war veterans who received one or more transfusions (presumably of blood containing Rh factors) have been sensitized to Rh, and assumes that in the general population a large number of women have been similarly sensitized with the distinct possibility that a future pregnancy may result in unmistakable evidence of the sensitivity.

Endometrial tissue, taken from different locations within the uterine cavity at the same time, will show a variation in histologic appearance. Burch and Phelps insist, however, that endometrial biopsies, done pre-operatively accurately reflect the status of the endometrium. They hold that positive diagnosis of carcinoma of the uterus can be made from a biopsy specimen in more than 75 per cent of cases, but admit the advisability of curettage to avoid a small localized lesion if the biopsy specimen is negative and carcinoma is strongly suspected.

There is much interest now in the diagnosis of uterine cancer by vaginal smears. Taking the smear is a very simple matter; the staining not so simple, though still an "office procedure"; however, the interpretation and evaluation of the cells and deciding on a "yes or no" diagnosis of uterine cancer is an undertaking only for the well-trained and experienced pathologist. According to Freemont-Smith, in 6 of 39 proved cases of cancer of the endometrium, no cancer cells could be found in the smear; and technical errors (chiefly inadequate searching of the slides) caused incorrect negative reports in 10 per cent of the cases. False positives were reported in 3 per cent of cancer-free cases making a total diagnostic error of 4 per cent for the combined groups. Although ideal for screening of large masses of the population, the smear method "will never supersede the biopsy". In only rare instances have the authors advised operation on the basis of a positive vaginal smear without corroboration of the diagnosis by examination of a fixed tissue specimen.

The advantages of visualization of the abdominal viscera by pelvic culdoscopy is emphasized by Albert Decker. He reports 300 such examinations of which 229 were completely satisfactory in that a detailed diagnosis, confirmed by laparotomy, was possible.

MENSTRUAL DISORDERS

Irving Stein's opinions as to the inefficacy of endocrine preparations and the x-ray in the treatment of amenorrhea and the good results of wedge resection of bilateral polycystic ovaries have not met with wide acceptance. E. C. Hamblen strongly advocates the cyclic estrogen-progesterone treatment for functional excesses of uterine bleeding, and cyclic gonadotropin, equine and chorionic, for sterility due to lack of ovulation.

An interesting method of evaluating dysmenorrhea is presented by Ingersoll. Since primary dysmenorrhea is always associated with ovulation and secretory endometrium, Ingersoll suppresses ovulation by large doses of estrogens. Withdrawal of the estrogen is followed by anovulatory bleeding which in the normal, healthy female is completely painless. If the patient complains of pain in association with this "withdrawal bleeding", it is safe to assume that the cause of the dysmenorrhea is

* Based on a review of *Progress in Gynecology*, edited by J. V. Meigs and S. H. Sturgis. Grune and Stratton, New York, 1947.

emotional rather than organic and that even pre-sacral neurectomy will prove unavailing. Psychotherapy is indicated.

ENDOCRINE ASPECTS

J. P. Pratt's article on "Masculinization, Virilism, and Hirsutism" is informatory, and sensible. It avoids extremes of opinion in either direction. His discussion of the diagnostic value of determination of the 17-ketosteroids in the urine in suspected cases of adrenogenital syndrome is especially clear.

Helene Deutsch, who has had such a large experience in the psychologic problems of women, contributes a thoughtful and thought-provoking paper on the "Psychiatric Component in Gynecology". The close relationship between the mind and the genital organs and their function is well known to all practitioners, especially gynecologists.

M. Edward Davis reports that no proved effects on the human ovary have ever been achieved by the use of any of the commercial preparations of chorionic gonadotropins. Some of us who have successfully used these products may differ with the author on that.

Reifenstein emphasizes the role of hyperplasia or tumor of the adrenal cortex in the production of the Cushing Syndrome. Reifenstein says that "surgical removal of part of the hyperplastic adrenal cortical tissue and radiation to the adrenals have not been effective therapeutic measures. Radiation of the pituitary gland, however, has resulted in alleviation of the condition in several patients." He believes that "the most important hormonal therapy is the administration of testosterone compounds. . . . which cause masculinization, an undesirable effect more than offset by the benefits obtained from increased anabolism of protoplasm and decreased corticosterone-type hormone production". Since Cushing Syndrome is caused by a basophilic adenoma of the hypophysis (although it can be simulated by adrenal cortex tumor) and since one of the components of the syndrome is hirsutism, I can not understand Reifenstein's indictment of the adrenal, rather than the pituitary gland. His use of the masculinizing testosterone is puzzling, since he acknowledges good results from irradiation of the pituitary.

Udall J. Salmon recommends combined estrogen and androgen administration in certain menopausal cases in order to minimize the effects of estrogen on the size of the breasts and to prevent estrogen bleeding. If such estrogen effects must be prevented, I prefer to reduce the estrogen dosage rather than neutralize it by the concomitant administration of expensive androgens. Some of us deplore the very high dosage of estrogens for the relief of menopausal symptoms. Much smaller dosages would relieve the vasomotor and mental disturbances without causing breast hyperplasia or endometrial bleeding. Salmon's treatment of frigidity in the female by large doses of androgens seems strange, especially as he also administers estrogens. I have always felt that sexual frigidity (in an otherwise normal, adult female) is due entirely to psychogenic factors. Intelligently conducted psychotherapy with or without the help of treatment with estrogens, (whose effect may in these cases be largely psychic) would seem a more rational approach to the problem than exhibition of androgens.

STERILITY

It frequently happens that women coming to me for sterility investigation have previously been attended for the same problem by one or more doctors. To my surprise, questioning of the patient not uncommonly elicits the information that these practitioners have expressed a positive opinion as to fertility or lack of it in the couple, without ever having done more than a bimanual examination of the female partner. I have been told in a few instances that parenteral administration of glandular products has been carried on, after such an unbelievably inadequate examination, for a period of a year or more presumably in an effort to "regularize the menstrual flow" or to "make small ovaries and uterus larger". There are several fundamental examinations which must be done on the infertile couple, (and this is well brought out in John Rock's paper) before any opinion as to sterility can be ventured. If the genital anatomy of the couple is normal, there are three basic conditions which must be present for pregnancy to be possible and these should be determined before search is made

for less common causes. The woman must produce an ovum, the ovum must be able to get into (and through) the fallopian tube, and the man must produce relatively normal sperm. Most cases of sterility are caused by failure of one or more of these three fundamentals. Basal temperature records, compiled by the woman for two or three menstrual cycles, will usually show if and when ovulation occurs, a much simpler method than repeated endometrial biopsies. Utero-tubal insufflation, (preferably using carbon dioxide and a kymograph for a permanent visual record) repeated, if necessary using anti-spasmodic drugs, with or without salpingography are simply done methods of determining tubal patency. Sperm examination is an office procedure no more difficult than a complete blood count and includes a count, motility study, and morphologic study of a stained smear. A simple determination as to whether motile sperm are present in the specimen is hardly sufficient. Most of the causes of sterility or infertility will be found among these three examinations. If not, some or all of the other diagnostic measures can then be carried out, as so well described in F. A. Simmon's "Diagnostic Technics and Treatment of the Sterile Couple".

BACTERIAL AND PARASITIC INFECTIONS

Not all cases of vulvo-vaginitis in little girls are caused by the gonococcus. Everett has an excellent article in the book on management of foreign-body vaginitis, trichomonas, and fungus infections as well as a discussion of estrogen and penicillin treatment of gonorrheal vaginitis.

The paper titled "Chronic Cervicitis" by Mortimer N. Hyams might fairly be called a classic. We all know of his intense interest in the treatment of this condition, and while he is naturally prejudiced towards "conization" developed by him many years ago, he equitably presents the advantages and disadvantages of cauterization, ionization, coagulation, and surgical procedures.

Trichomonas vaginalis infections are common. The incidence is about 10 per cent of all women and much higher in pregnancies. Sophia Kleegman treats the very acute phase with Lassar's paste on small lamb's wool tampons. This plus the use of carbasone suppositories is the treatment used in most cases and only occasionally does she use the powder-blower treatment with a pentavalent arsenic powder. In stubborn or recurrent cases, treatment of the bladder and urethral glands may be necessary before permanent cure is obtained. Apparently the author does not attach importance to the possibility of an intestinal source.

Frederick J. Lynch treats miscarriage and septic abortion by early emptying of the uterus in spite of the presence of fever. He quotes statistics to prove that mortality is actually lower in those cases handled "actively" than in those given "conservative" treatment. He feels that in cases of incomplete miscarriage with fever, (excluding frankly septic cases with involvement of perimetrial tissues) the fever is caused by a saprophytic infection of the uterine contents and that the sooner the putrefying secundines are removed, the sooner the patient will be well.

ENDOMETRIOSIS

Endometriosis is found in about 30 per cent of all abdominal gynecologic operations. There is a probability of a still higher percentage in cases not coming to surgery. Not long ago a prominent New Jersey surgeon presented a case report at a staff meeting of a local hospital. He had performed an intestinal resection for a lesion which, on pathologic examination, was found to be an endometrioma of the intestinal wall. He confessed that he had not previously known that endometriosis could cause such a lesion, or he would not have done the resection under the assumption that a malignant neoplasm was present.

CARCINOMA OF UTERUS AND CERVIX

Randall feels strongly that there is some connection between estrogens and endometrial carcinoma and cites the fact that in a study of a large series of cases, 35 per cent of the women with adeno-carcinoma of the fundus had continued to menstruate past the age of fifty. But among women who had not developed carcinoma within a fifteen year period following menopause, only 8 per cent had

menstruated beyond their fiftieth year. This sounds like a significant difference as regards duration of endometrial stimulation. He also feels that long continued administration of estrogens in high dosage is inadvisable. I recently saw sections of curettings in the case of a 26 year old woman who was completely healthy except for sterility. A diagnostic curettage was done and a competent pathologist made a positive diagnosis of endometrial cancer. When the attending physician expressed doubt, it was learned that this patient had been receiving high doses of estrogens for some time. Another curettage done one month later, (during which time no estrogen was given) showed a normal endometrium.

Although there are no proved cases of carcinoma caused by estrogen administration, it must be remembered that estrogens do have the same fundamental "cholane" chemical structure as do experimentally used carcinogenic substances. We should be more circumspect in our use of endometrium-stimulating products especially for patients in the "cancer decade".

With regard to preoperative radiation which Randall recommends for adenocarcinoma of the fundus, I must take issue with the author. Adeno-carcinoma, especially of the mature type characteristic of fundal carcinoma, is relatively radio-resistant. I have seen extirpated uteri which had been exposed to radiation, preoperatively, in the usual manner, where only the lowest and most superficial portions of the malignant growth showed postradium necrosis while the bulk of the tumor was completely unaffected. In one case there was a small metastasis to an ovary which might well have occurred during the four months usually allowed to elapse between radiation and hysterectomy. The amount of radiation necessary to have a sclerosing effect on the entire mass of a fair sized carcinoma would cause disastrous changes in the bladder and rectum and is therefore impossible. Immediate panhysterectomy following diagnosis by curettage (with possibly postoperative roentgen irradiation for the surgeon's peace of mind) will give better long-term results than ineffective preoperative radiation and surgical delay.

Richard Te Linde takes a very definite stand on the "Relation of Intra-epithelial Carcinoma to Invasive Cancer of the Cervix". This lesion (also known as *carcinoma-in-situ,* Bowen's disease, and preinvasive carcinoma) has been the basis of much disagreement among pathologists as to its malignancy and among surgeons as to the proper management. Te Linde feels that this is an early stage of invasive cancer of the cervix and should be treated radically without delay.

How about radium and x-ray therapy of cancer of the cervix? Surgical therapy is of little avail except in Group 1 (League of Nations classification). The only recourse in Groups 2, 3 and 4 is radiation which, in hands not expertly skilled, can do more harm than good. The radio-therapist needs therefore, an exact knowledge of the patient's probable reaction to radiation, the extent of the lesion, amount and method of application of the modality whether it be intravaginal and intrauterine radium, interstitial radon needles, or high voltage x-ray to the pelvis from without or intravaginally via cones.

Believing that it is not possible with radiation to cure cancer in lymph nodes deep in the pelvis, Meigs resorts to surgery in such cases. He uses a combination of the Wertheim hysterectomy and Taussig's node dissection, with routine removal of all nodes from the common iliac artery, along the external and internal iliac arteries, into the obturator foramen (with exposure of the obturator nerve) and the removal of as much of the parametrium and vagina as possible. He does a meticulous dissection of the ureters out of their channels around the cervix and vagina down to the bladder, carefully preserving three of the five arteries supplying the ureter, thus avoiding necrosis and ureterovaginal fistulae. It is a long, tedious and painstaking operation but one which Meigs feels can be accomplished without too much difficulty by a good surgeon. In the operated group followed for three years, of seven who had positive lymph nodes at the time of their operations five died. Excluding these, Meigs finds that 92 per cent are living and well at the end of three years. In his 1947 edition, Curtis, in discussing the "Wertheim

operation", says "if the operation is thoroughly done, there is little to be accomplished by additional search for pelvic lymph nodes as recommended by Taussig and more recently by Meigs".

Daniel G. Morton concludes that modern roentgen therapy can, and often does, destroy cancer in the regional lymph glands and that the operation of pelvic lymphadenectomy is unnecessary and should not be regarded as part of routine treatment of cervical cancer.

OPERATIVE SURGERY

More and more surgeons are now convinced that total hysterectomy is to be preferred to the subtotal. Masson of the Mayo Clinic has come to that conclusion and rejects the usual objections to the total operation, namely, increased morbidity and mortality rates, poor support for the vaginal vault, shortening of the vagina, and dyspareunia. At the Mayo clinic, mortality rates for the subtotal hysterectomy have been 0.7 per cent while that for the total hysterectomy was 0.6 per cent. Recently Henry Falk and associates presented a series of papers indicating that his morbidity and mortality rates for the two operations was about the same. So convinced is he of the merits of total removal that he scarcely does the subtotal operation. Incidentally, Falk's moulages showing every step in the operation are beautiful works of scientific art well worth inspection and study.

Louis E. Phaneuf writes on the "Management of Prolapse of the Uterus and Vagina", a study based on 900 personal operations, and he has apparently tried every type of operation ever devised. From his statistics he seems to have preferred in descending order the interposition operation, vaginal hysterectomy, vaginal plastic repair plus suspension of the uterus, and the Manchester-Fothergill (parametrial fixation) operation. In all, seventeen different methods are described and discussed.

Meigs' discussion of entercele or posterior vaginal hernia is short but to the point. Enterocele is frequently misdiagnosed as a rectocele. Repair of the latter does not, of course, cure the former. An important step, not particularly emphasized by Meigs, is the suturing together of the utero-sacral ligaments to prevent recurrence.

The Meigs-Sturgis *Progress in Gynecology* contains a mine of information of interest to the general practitioner and of importance to the gynecologist, and a valuable addition to the personal library of either.

78 Clinton Avenue

COURSE IN INDUSTRIAL MEDICINE

An intensive graduate couse in industrial medicine is announced for the two-week period beginning April 5, 1948. This is sponsored by the Long Island College of Medicine. It will provide physicians with practical information on recent developments in industrial medicine. A schedule and application blank may be obtained from Dr. Thomas Dublin, 248 Baltic Street, Brooklyn 2.

MEMO TO CORNELL ALUMNI

Cornell University Medical College celebrates its semi-centennial this year. A program of special interest to medical alumni is planned for March 11. For a detailed program write to Cornell University Medical Alumni Association, 1300 York Avenue, New York City 21.

CONFERENCE ON ALCOHOLISM

The first Industrial Conference on Alcoholism will be held on Tuesday, March 23, at the Morrison Hotel in Chicago. The conference has been designed to bring to the attention of industrial leaders throughout the country facts pertaining to the problem of alcoholic employees and to discuss ways and means of overcoming the problem.

AMERICAN BOARD OF OPHTHALMOLOGY

The next practical examination for applicants for the Diploma of the American Board of Ophthalmology will be held in Baltimore during the four-day period beginning May 20, 1948. Further information may be obtained from the American Board of Ophthalmology, Cape Cottage, Maine.

HISTAMINE HEADACHE

Joseph L. Witkowski, M.D., Camden, N. J.

Histamine headache, originally described as *erythromelalgia of the head* is also known as Horton's syndrome. Horton [1] was able to produce this headache by administering histamine subcutaneously and to relieve it, in most cases, by giving epinephrine or other vasoconstrictors intravenously. Histamine headache is characterized by intense pain, usually one-sided, which begins abruptly. Attacks often occur during the night, and awaken the patient out of a sound sleep. Duration varies from fifteen minutes to several hours. The headache is frequently associated with profuse watering and congestion of the eye, increased surface temperature and stuffiness of the nostrils. There may be swelling of the temporal vessels on the affected side of the head. Distribution of the pain is along the course of the external carotid artery. There are no gastro-intestinal symptoms except occasional nausea. No hereditary background accounts for the headache. Ingestion of alcohol [2] often precipitates an attack.[3]

I have observed and treated, with apparent success, over a period of one year, four cases of histamine headache.

CASE ONE

A middle aged steel worker, who had been exposed to the cold weather while at work, complained of throbbing headache, with a pounding of the blood vessels on the left side of the head. The left eye was watery, and showed vascular injection. There was no visible flushing of the face. His headache recurred several times a day, lasting from one to several hours before he sought relief. Histamine by subcutaneous injection was administered with resultant freedom of pain in approximately ten minutes. He had to receive a daily histamine injection for a week before he had complete freedom of pain.

CASE TWO

A thirty year old housewife complained of hemicrania which had been present for several weeks. The eye on the affected side was watery, and seemed to be irritated. She was an emotionally unstable person, and had been unable adequatcly to adjust herself to a change of environment. Along with these headaches, she also had some nausea so that she would force herself to vomit. She had no visual disturbances. She was given histamine by subcutaneous injection with resultant relief from pain. Here again, it was necessary to re-administer histamine several times a day for three days. She did return two weeks later and the same treatment provided the same results. However, it is believed that this case can not be properly called a histamine cephalgia because migraine has not been excluded.

CASE THREE

A woman complained of a left sided headache for several days. The pain extended to the occiput. She felt that the blood vessels were pounding on the affected side of the head. The left side of the face felt warmer than the right. She had had an enucleation of the left eye, but stated there was a drawing of the muscles and irritation present. She was given histamine subcutaneously with complete cessation of the pain within ten minutes. There have been no recurrences.

CASE FOUR

A 19 year old female complained of a headache on the right side extending to the vertex and occiput. The headache existed for two days, and was described "as if the blood vessels were pounding on the right side of the head". Histamine was used subcutaneously, and there was remission of pain in about ten minutes.

While serving in the armed forces, I had the opportunity to observe a patient with histamine cephalgia, who, when free of headache, would suffer the pain again following the intravenous injection of histamine. The same headache could then be controlled by subcutaneously administered histamine. The experimentally produced pain in this case revealed the classical manifestations. In addition, I had also observed and treated an officer with a typical histamine headache by desensitization with good results. This officer, had to have several series of desensitization to histamine before a maintenance dose could be reached.

DIAGNOSIS

Migraine is to be differentiated by the longer duration of the attacks, and the co-existence of nausea, vomiting, and visual disturb-

1. Horton, B. T.; MacLean, A. R., and Craig, W. M.: Proceedings of Staff Meeting of the Mayo Clinic, 14:257 (March, 1939).
2. Horton, B. T.: Journal of the American Medical Association, 116:377 (1941).
3. Lieder, L. E.: Annals of Internal Medicine, 20:752 (1944).

ances. In addition, there is, as a rule, a familial background. Trigeminal neuralgia is distinguished by the presence of trigger zones, which are not present in histamine cephalgia. Also the distribution of the neuralgia is along the course of the fifth nerve or one of its branches. The pain in histamine cephalgia follows the course of the external carotid artery.

TREATMENT

Presumably any agent which inhibits anaphylaxis should have a salutary effect on the allergic process.[4] In this connection, Goodman and Gilman [5] write: "Histamine headache, once initiated, can be interrupted by a second injection of histamine, or by any other procedure which raises the cerebrospinal fluid pressure or quickly lowers the arterial blood pressure." This is substantiated in the reports of Horton,[2] who observed relief of pain by using epinephrine in some of his cases.[1] He had also noted cessation of pain by having the patient immerse his hands in ice water. However, success is attained by desensitization of the individual by beginning with 0.25 cubic centimeters of a histamine acid phosphate solution containing 0.1 milligramme of the histamine base per cubic centimeter. This dose is administered twice daily and successively increased by 0.05 cubic centimeters until one cubic centimeter is reached. If a reaction is obtained, the last administered dose is reduced to one half and a gradual increase attempted again. Following this, a maintenance dose is given several times weekly [6] if necessary. An associate of Horton's, used the decrease in size of the wheal and flare following intracutaneous injection of varying dilutions of histamine as an index of the patient's response to treatment.

THEORETICAL BACKGROUND

Hypersensitivity phenomena are believed to occur because of the action of histamine which is liberated as part of the antigen-antibody reaction.[7] Dale and Laidlaw [8] have stressed the similarity between anaphylactic shock and the action of histamine. It is now known [9] that histamine is a normal constituent of many tissues. A histamine-like substance has been indicted [10] as the cause of the urticarial wheal, and dermatitis associated with specific food allergies, is accompanied by lesions morphologically similar [11] to the urticarial wheal.

Histamine is a dilator of capillaries. It achieves this result without the mediation of the nerve supply to the vessels. Since it dilates cerebral and meningeal vessels, its injection is naturally followed by a fall in both cerebrospinal fluid pressure and general blood pressure.[5] The physiologic mechanism thus enables us to understand why histamine can both precipitate and control a headache.

1450 Mt. Ephraim Avenue

4. Editorial in the *Journal of Allergy*, 15:302 (April, 1944).
5. Goodman, L., and Gilman, A.: *The Pharmacologic Basis of Therapeutics*. Macmillan, New York.
6. Beekman, H.: *Treatment in General Practice*. Saunders, Philadelphia. 5th edition.
7. Ratner, B.: Journal of Pediatrics, 30:583 (May, 1947) and Feinberg, S. M.: Journal of the American Medical Association, 132:702 (May, 1947).
8. Dale, H. H., and Laidlaw, P. P.: Journal of Physiology, 41:318 (June, 1910).
9. Best, C. H., and McHenry, E. W.: Physiologic Review, 11:371 (March, 1931).
10. Lewis, Thomas: *Blood Vessels of the Human Skin*. Shaw, London (1927).
11. Lewis, T., and Grant, R.: Heart, 113:219 (February, 1926).

REHABILITATION AND TUBERCULOSIS

In tuberculosis, rehabilitation is a form of treatment. Obviously, during the period of diagnosis and early hospitalization, medical care is paramount; but, at some point during the period of hospitalization, vocational guidance and training constitute a large portion of treatment and are continued into the immediate post-sanatorium period.—Hilleboe and Kiefer, Pub. Health Rep., March, 1946.

THREE MILLION DEATHS

"Tuberculosis constitutes a humanitarian problem of great magnitude. The most recent comprehensive review, that of the United States Census Bureau in 1938, includes mortality figures for only thirty-two nations. The rates varied from 40 per 100,000 to 260. For a large part of the world's population, tuberculosis deaths are unrecognized, uncounted, or both. It is impossible, therefore, to make more than the roughest estimate of the toll which the disease exacts. It is safe to say, however, that there occur each year in the world more than three million deaths from all forms of tuberculosis and that the total probably exceeds five million." James A. Doull, M.D.

OPHTHALMOLOGY IN PEDIATRIC PRACTICE *

Lee W. Hughes, M.D., Newark, N. J.

Ophthalmologic problems begin as soon as the pediatrician assumes care of the infant. Many eye defects are developmental and no time should be lost in recognizing them.

The lids normally afford a natural covering as well as a protection to the eyeball itself. Should there be a disturbance in the mechanism of the closing of the fetal fissure there results a *coloboma* (which indicates that type of congenital anomaly wherein a structure of the eye is lacking) which may appear as a mere notching or at times, a large defect. A coloboma usually affects the upper lid.

It is possible to have a coloboma of the iris, choroid, lens or optic nerve separately or even all occurring in the same eye at the same time. While a coloboma of the lid lends itself to surgical correction, there is no known treatment for coloboma of the other structure of the eye. It is usual to have considerable impairment of vision in coloboma of the iris, choroid, lens or optic nerve, yet in some cases, vision is practically normal.

Gross developmental defects or deformities affecting the eye include atresia of the nasolacrymal duct, absence of upper or lower puncta, and double row of cilia.

Anophthalmia is complete failure in the outgrowth of the primary optic vesicle. In this condition the essential neuron structures are completely unrepresented in the eye. This is rare, and if a socket is examined very carefully some remnants of eye structures will be found.

In *monophthalmia,* (only one eye is present) the eye is usually abnormal and microphthalmic. Pure microphthalmia or congenital smallness of the eye without other deformities is rare.

Epitarsus is an apron-like fold of conjunctiva attached to the inner tarsal surface of the lid.

Epicanthus is a fold of membrane at inner canthus. It has a tendency to disappear when the bridge of the nose fully develops, and seldom requires surgery. Because of the widening of the bridge of the nose and the fold of skin at each inner canthus, convergent squint is often simulated.

Congenital ptosis is a drooping of one or both upper lids. Decision to operate should not be reached hastily. The surgical procedure usually consists of some shortening of the levator muscle.

"Blue sclerotics" is the term for a thin sclera giving a grayish blue color. It is caused by some parathyroid dysfunction, associated with myopia, conical cornea, deafness, and diseases of the bones.

Megalocornea is a bilateral condition in which the anterior segment of the eye is larger than normal. The most prominent features are an enlarged circumference of the cornea, deep anterior chamber, normal intra-ocular tension —usually good vision. It should not be confused with *buphthalmus* which is a structural abnormality in the region of the anterior chamber, interfering with the drainage mechanism of the intra-ocular fluids, resulting in an increase in the intra-ocular pressure, and a condition known as *congenital glaucoma.* The whole structure of the eye enlarges to such an extent that it is said to resemble an "ox eye". A case of buphthalmus should be operated on early if any vision is to be preserved.

Aniridia or *irideremia* is a condition in which the iris is rudimentary. There is always a portion of the iris present. The pupil is large and occupies the entire area of the cornea. The child is very sensitive to light and should wear dark glasses. In selected cases, tattooing of the periphery of the cornea should be attempted.

There are many anomalies of the inner structures of the eye, which, according to Krause, should be classed under the heading of *congenital encephalo-ophthalmic dysplasia.* The brain and the retina with their associated structures are affected by this disorder. It is characterized by retinal and cerebral hypoplasia and hyperplasia. The ocular disease,

* Read by invitation before the N. J. Section of the American Academy of Pediatrics, January 2, 1947.

according to Krause, is made manifest by the secondary changes; these include microphthalmus; malformation of the retina, choroid and optic nerve, retinal dysplasia; retinal glial membranes, cones and septa and persistent remains of the hyaloid artery. Retinal detachment is associated with the same process which causes retinal dysplasia.

The secondary effects are retinal atrophy, gliosis, fibrosis, intraocular hemorrhages and exudates, secondary glaucoma, atrophy of the iris, anterior and posterior synechiae, cyclitic membranes, choroidal and scleral atrophy and cataracts.

The signs of the disease are usually hidden at birth and may become evident later on by close examination.

Retrolental fibroplasia is the development of embryonic tissue in the meshwork of the persistent hyaloid artery system, behind the crystalline lens as a result of improper development of the inner eye—usually developing three to five months after birth in the extremely premature infant. Four to six months after birth the greater number of these infants present symptoms of blindness — nystagmoid movements, gray pupillary reflexes, shallow anterior chambers, and usually a small eye. Most of these infants are born prematurely twenty-seven to thirty weeks gestation.

Retinoblastoma or *glioma* is a very malignant disease of the retina. Most of the cases are found between the first and fourth years of life. It is first recognized by the picture of the "amaurotic cat's eye". Such an eye is blind, the pupil wide and fixed and presents a whitish-yellow or golden-yellow reflex. It must not be confused with pseudo glioma or tunica vasculosa lentis. The treatment is early enucleation. Some patients have responded to radiation therapy.

Congenital *cataract* is usually present at birth, though it may not be recognized during the early weeks of infancy. Griggs of Australia and at about the same time, Reese of New York, along with several others called attention to the fact that pregnant mothers contracting measles during the first three months of pregnancy gave birth to children suffering from congenital cataracts in eighty per cent of their cases. However, this high ratio has not been found by other observers. While it is generally agreed that congenital cataracts are the result of some toxic condition arising in the uterus during the early months of pregnancy, it is just as reasonable to assume that they can be caused by toxic conditions other than measles.

Congenital cataracts are usually bilateral, and if they are sufficiently dense to interfere materially with vision, they should be operated on in the early months of infancy, preferably before the child has developed any nystagmoid movements. In an otherwise healthy infant it is my feeling that they can be subjected to operation any time after three months of age, since we must remember that children suffering from congenital cataract often develop an early amblyopia.

Amaurotic familial idiocy (Tay Sachs disease) is an hereditary disease affecting infants, found mostly among the Jewish race, but also occurs among foreign groups, characterized by a cherry-red spot on the macula, optic atrophy, and eventually blindness. Patients usually die before two years of age.

Mongolian idiocy is manifested by a baby of apparently happy disposition, presenting nystagmus, lens opacities, dwarfism, flat nose and large gaps between first and second toes. Such patients usually die of other diseases during early childhood.

In *arachnodactly* (Marfan's syndrome), congenital bilateral dislocation of the lens is present at birth. Later changes include abnormally long bones of legs, arms, hands and feet and a scoliosis. The patient first complains of interference with the vision because of the malposition of the lens.

Retinitis pigmentosa is a degeneration of the retina in which the visual cells disappear, with typical bone corpuscle pigment spots throughout the retina. It is more common in males than in females, and often there is a history of consanguinity. Earliest symptom is inability to see in poor light or in the dark. The degenerative processes usually lead to atrophy of the retina and optic nerve.

Congenital word blindness is commonly not discovered until the child reaches school age.

It is characterized by apparent inability to read. Some are helped by teaching the child to read with persistence on the part of special teachers.

Color blindness is most commonly seen in the form of red-green blindness. It is more frequent (by thirty-five to one) in males, though it is transmitted through the female.

Diabetes in children may cause a sudden swelling of the lens eventuating in cataract, which may require operation.

Tuberculosis causes certain diseases of the eyes. Perhaps the one most commonly seen in children is *phlyctenular conjunctivitis*—which usually clears up with rest, fresh air and proper diet.

The most common eye disease resulting from congenital syphilis is *interstitial keratitis*—usually coming on at the age of puberty, often resulting in partial or complete blindness if not treated early and thoroughly.

Cerebro-spinal meningitis may cause basilar arachnoiditis, transient blindness, optic atrophy, and metastatic enophthalmitis.

The acute exanthemata are associated with some of the inflammatory diseases of the external coats of the eye. Unless the cornea is involved there is seldom marked impairment of vision.

The same diseases of the external coats of the eye are seen in children as in adults and, in most cases, respond to the same treatment. Many cases of conjunctivitis that do not respond to treatment are caused by a specific organism, such as the gonococcus or the pneumococcus and require special treatment. We are all too prone to prescribe simple eye lotions in all forms of eye inflammations without knowing the type of infections we are treating. Boric acid and argyrol have ruined more eyes than they have ever cured.

Blepharitis is a crusting of the lid margins, usually caused by a refractive error, faulty diet or a staphylococcus infection. It ordinarily responds to proper treatment.

Vernal catarrh or *"springtime catarrh"*, a roughening and papilliform inflammation involving the tarsal conjunctiva and (to a less degree) the bulbar conjunctiva. It is thought to be an allergic disease, and is most severe during the spring and summer months. Remissions occur during the fall and winter only to recur the following spring.

Diseases of the cornea, sclera, iris and ciliary body are not as prevalent in children as adults. The disease causing most blindness in children is interstitial keratitis, and the most common cause is congenital syphilis.

One of the most frequent eye conditions confronting the pediatrician during the early months of infancy is related to the lacrymal apparatus. The first symptom is usually persistent watering of one or both eyes—which later may present a mucopurulent discharge from the conjunctival sac. If there is any doubt regarding the diagnosis, firm pressure should be made with the thumb or index finger of the examiner over the region of the lacrymal sac. If there is any interference to the flow of tears, thick tenacious mucus or muco-pus will appear in the conjunctival sac.

Treatment should begin as soon as the diagnosis is made. The mother is instructed to make firm pressure over the region of the infant's lacrymal sac several times daily. This is followed by instillation of some astringent eye lotion into the lower conjunctival sac. Should this condition fail to clear within three or four weeks, it will be necessary for the eye physician to probe the naso-lacrymal duct to break up any constriction that might interfere with the free flow of the tears.

Probing the naso-lacrymal duct is a simple procedure which can be carried out in the physician's office under a local anesthetic dropped into the conjunctival sac. An eye lotion of borax, boric acid, adrenalin, and distilled water is given to the parents with instructions that they instill it into the conjunctival sac several times daily over a period of several weeks or until watering of the eyes has entirely disappeared; again instructing the parent to make firm pressure over the region of the lacrymal sac before the instillation of the eye lotion.

One probing of the lacrymal sac may be sufficient. In some cases where treatment has been delayed, it will be necessary to repeat the probing two or even three times; never, in my experience, has it been necessary to remove

the lacrymal sac. However, it has been carried out by other ophthalmologists.

Probing the lacrymal sac under good local anesthesia causes very little pain or discomfort. Only under the rarest of conditions should the child be subjected to the risk of a general anesthesia.

When we feel that the child presents signs and symptoms of poor vision, he should be referred to the ophthalmologist for examination and, if necessary, the prescription for glasses. There has been a great deal of resistence on the part of the parents (as well by the attending physician) to the wearing of glasses especially in children of two years or younger. Practically every child is born with a fair degree of farsightedness, which has a tendency to decrease during early childhood or until the age of puberty when the patient may become emmetropic or develop myopia. While it is possible that the farsighted child may discard his glasses when he grows older, the myopic child usually has to wear his more or less constantly. It is not unusual for myopia to develop as early as the third or fourth year of life or even earlier. The usual tendency is for it to become progressive. Therefore, every effort should be made to encourage the child to develop proper reading habits. When there is an increase in the myopia there should be frequent changes of glasses, and parents are encouraged to have the child report regularly for a check on the vision.

One of the most perplexing problems of the pediatrician is the care of the cross-eyed patient. The strabismic child is usually neglected until he arrives at an age when his condition is incurable. Even in this day of advanced medical knowledge, all too often the parent is told that squint is something that will disappear as the child grows older. Thus valuable time is lost, as well as the forfeit of a cure unless the treatment of squint is started as soon as the diagnosis is made.

Movements of the eye are not fixed during the early months of infancy, since the fusion faculty is not developed before the sixth month. Yet cases of a true paralysis of one or more of the extra-ocular muscles is often manifest at birth or shortly afterwards. As soon as it is established that the child has any limitation of motion of the eyes, he should be referred to the oculist for examination and an opinion.

What causes strabismus? Many different theories have been advanced, among them the muscular theory that maintains that a concomitant squint is due to a too strong overacting rectus muscle as compared to its antagonist which causes the eye to turn in or out. Then there is the accommodative theory of Donders, that squint is produced by disturbance of convergence and accommodation due to hyperopia or hyperopia and astigmatism. Mention must also be made of the fusion theory. (The uniting of the two retinal images into one mental image is called fusion.) In lack of fusion there is a suppression of the retinal images of one eye causing the eye to turn in or out. When the fusion faculty is well developed the desire for binocular vision is so great that it will keep the two eyes straight.

There are many contributing causes of squint such as farsightedness, marked difference of refraction between the two eyes, reduced vision in one eye (amblyopia), structural anomalies, acute illness, birth injuries (which act by producing a paralysis of one or more extraocular muscles), and also such factors as fright, irritating effects of intestinal parasites, malnutrition and general nervousness associated with one or more of the already mentioned causes of squint.

Six extraocular muscles control the movements of the eyeball. While the main movements of the eyes are internal and external rotation, elevation and depression, it is possible to have involvement of one or several muscles in a case of squint.

First step in the treatment of any type of squint is to determine the error of refraction under the full cycloplegic effect of atropine. Most cases of convergent squint are hyperopic. The type that responds most readily to the wearing of glasses is the accommodative type. It is advisable to give the child the full cycloplegic refraction as early as eighteen months.

Most cases of divergent squint are myopic. Correction of the myopia will tend to give a

stimulus to convergence. Whether a squint is convergent or divergent, it is essential to correct astigmatism so that a clear retinal image is obtained since there is nothing as essential in stimulating vision.

A monocular convergent squint usually is accompanied by some degree of amblyopia, regardless of the age of the child. As soon as the case has been diagnosed, some attempt should be made to improve vision in the squinting eye. In the very young child, atropine can be used in the non-squinting eye once daily over a period of several months or until the child is old enough that vision can be taken. Then the better eye is occluded until the vision is improved to such a point that the examiner is reasonably sure that it cannot be improved further. There is nothing more important in the treatment of a monocular squint than some form of occlusion to the sound eye. The occlusion to be of any real value must be total and complete during the waking hours of the child. The earlier the treatment, the quicker the results; indeed, it is thought by many ophthalmologists that occlusion to be of any real value must be carried out before the seventh year of age. Should the child have any refractive error, he should be wearing his glasses all the time during occlusion of the better eye.

Orthoptic treatment should not be started much before the fifth year of age or until the time that the technician can secure the full cooperation of the child. Yet efforts should be made to stimulate vision by means of glasses or occlusion until the child arrives at an age that permits orthoptic treatment.

A conservative estimate of thirty to forty per cent of cross-eyed children can be cured by means of glasses or orthoptics or a combination of both, but rarely is a cure effected without operation when the angle of squint is greater than twenty degrees. Alternating squints whether convergent or divergent usually come to operation and practically every case of squint, (when there is a paralysis of one or more of the extraocular muscles) will require surgery. When should surgery be performed? It is my feeling that practically every case of squint requiring surgery should be carried out before the child reaches school age.

Good vision is a priceless heritage; every effort should be made to maintain it.

965 Broad Street

AMEBIC APPENDICITIS

Subacute appendicitis may be the only indication of amebic infection. To prevent more serious complications, medical treatment should be followed by appendectomy. In Palestine, *Amoeba histolytica* causes 30% of all cases of subacute or chronic appendicitis. In a consecutive series of 50 appendixes removed at Haifa Hamzah found 13 with ulcers containing living amebas, seen in smears and tissue sections.

Externally the appendix appears normal or slightly thickened and is seldom distorted and adherent. The mucosa is normal except for two or three grayish, sanguineous sloughs covering undermined ulcers.

Typical symptoms are slight dragging pain in the right lower abdominal quadrant and tenderness over McBurney's point, persisting for several months or years. Occasional mild attacks of appendicitis, dysentery, or habitual constipation may occur. The leukocyte count is normal. Since amebic cysts are often present, stools should be examined in all cases of subacute appendicitis.—Journ. Arabian Med. Ass'n. 1:74.

HIATUS HERNIA

Hiatus hernia of the stomach may be a source of intestinal bleeding and may resemble other more common intra-abdominal conditions. Four such cases are reported by Mendelsohn. In one patient symptoms simulated those or cardiac disease; in the second, bleeding duodenal ulcer; in the third, malignant neoplasm; and in the fourth, signs of heart disease were present but the patient had been repeatedly examined for tuberculosis because of hemoptysis.

Bleeding with hiatus hernia is caused by venous congestion of the herniated portion of the stomach, due to muscular compression by the diaphragm. The swollen mucosa is easily traumatized and superficial erosions or deep ulcerations occur.

A hiatus hernia, demonstrated by roentgenograms, should be considered as the cause of intestinal bleeding and pain when other possible sources of hemorrhage have been eliminated by clinical and roentgenologic examination.—Radiology 46:502.

NEWARK BETH ISRAEL HOSPITAL CANCER CONFERENCE *

William Brams, M.D., Newark, N. J., Chairman

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Max Danzis, M.D.

SARCOMA OF SOFT PARTS

The original description of sarcomata as soft, bulky, encephaloid, vascular neoplasms does not apply to all such tumors. Indeed, the frequently encountered fibrosarcoma meets none of these criteria.

Fibrosarcomata are malignant tumors composed of cellular connective tissue. They are distributed throughout the soft tissues of the body. Some authorities are of the opinion that they develop after a traumatic episode, the tumor being considered an exaggeration of the reparative process. They may remain dormant for many years, then grow rapidly and metastasize. Commonest site of metastasis is the lungs. The tumor first grows by local infiltration, and after removal is likely to recur locally. The prognosis is unfavorable. A firm, irregular, poorly delineated mass is usually found. Microscopically, varying proportions of spindle and round cells are seen; the round cell tumors being the more malignant. With recurrence, the histologic picture may at times show less maturity and more cellularity than the original tumor.

Desmoids are fibromata or fibrosarcomata from the rectus abdominus muscle sheath. They compose five to ten per cent of all fibrosarcomata. Ewing points out the frequency with which these are related to trauma, such as that sustained by the rectus abdominus muscle during child-birth. These tumors are very firm, and may reach such size that surgical removal results in a large abdominal defect. Desmoids are of low grade malignancy, and complete removal is not followed by recurrence. As a rule, the prognosis is good. Microscopically, desmoids range in appearance from mature fibrous tissue, to more cellular spindle cell tumors.

Neurogenic sarcomata are malignant tumors from the connective tissue of nerve trunks. They may remain static for years and then grow rapidly. In the early stages, they appear to be innocent connective tissue tumors. After removal of these apparently benign tumors, there frequently is local recurrence, but rarely distant metastases. They are known to spread along the epineurium. Wide excision of one lesion does not exclude local recurrence, since the so-called recurrence may be a new lesion further along the same nerve. These cases usually terminate fatally, but the slower growing ones are encapsulated and have a more favorable prognosis. Amputation may be necessary if there are repeated recurrences on an extremity. The tumors vary in structure from the slow growing, fibrous type to the anaplastic cellular type.

Liposarcomata are malignant tumors derived from fat tissue. They occur whenever fatty tissue is found, most often retroperitoneally and in the thigh. The thigh lesions may be subcutaneous or intermuscular. Some are encapsulated at first, but when they grow rapidly they break through the capsule and infiltrate the surrounding tissue. These tumors are highly malignant, and may metastasize.

Rhabdomyosarcomata are malignant tumors of voluntary muscle. They are most frequently found in the limbs, the trunk, and the tongue. A firm, round mass is felt which may move with the muscle. The slowly growing tumors are encapsulated. The more frequent rapidly growing ones grow by infiltration, and recur locally after removal. Myxomatous degeneration is not unusual. Rhabdomyosarco-

* This is from the 1947 spring conference at the Newark (N.J.) Beth Israel Hospital. Participating members of the Cancer Committee are: Doctors William Antopol, William Brams, Max Danzis, N. J. Furst, Louis J. Levinson, Charles M. Robbins and Max Singer. Dr. J. Harris, Fellow in Pathology, also participated in the work of the committee.

mata are known to metastasize to the lungs and liver. The tumor is fleshy and elastic, though at times the muscle septae are calcified or ossified. Microscopically, spindle cells and round cells are found in varying proportions, along with enormous, often bizarre, giant cells. Numerous and prominent nucleoli are present, as well as longitudinal and sometimes transverse striations.

Synovial sarcomata, otherwise known as *synoviomata,* are malignant tumors of malignant synovial tissue. They occur in three main locations: articular surfaces, bursae, and in fascia. Because of their location, their development usually causes discomfort or pain. These tumors grow rapidly and tend to recur after local excision. The recurrent tissue at times appears to be more malignant than the original tumor, and may give rise to pulmonary metastases. Prognosis is unfavorable. They present an imperfectly circumscribed soft to firm, sometimes vascular mass, usually near joints or tendon sheaths. They often adhere to bones and invade either into or between soft tissues. When they perforate a bone, they may be mistaken for a primary bone tumor. Microscopically, a great variety of cell forms is seen. However, sheets of large spindle cells with many mitoses make up much of the picture.

Myxosarcomata are highly malignant tumors from embryonal mucous tissue. They are most frequently found in loose structures which contain fat, such as the thigh, neck, cheek, leg and peritoneum. They are most often found in combination with other sarcomata, and are probably the result of myxomatous degeneration. Fibromata, lipomata, chondromata, neuromata and their malignant sarcomatous counterparts are the tumors which most commonly are either partly or completely transformed into myxomatous tissue. Epithelial tumors which are undergoing myxomatous degeneration must be distinguished from myxosarcomata. Local recurrences after surgical removal of these malignancies is common, and may be accompanied by metastases. Prognosis is not favorable. The tumors are cellular, vascular and have but little matrix, which is basophilic.

Osteochondromyxosarcomata of soft tissues are highly malignant, conglomerate tumors. We have a case which developed in a myositis ossificans. The structure of these tumors depends on the characteristics and proportions of the component tumor types.

Most of the patients presented in this group of soft tissue sarcomata were treated by local excision and subsequently referred for postoperative radiation therapy. Some received preoperative radiation therapy in an attempt to devitalize the tumor before local excision. These tumors are considered primarily as surgical problems. Response to radiation therapy is for the most part unsatisfactory; most soft tissue sarcomata are in the radio-resistant group.

In all, we had twenty-five cases of soft tissue sarcomata and the chart demonstrates the frequency and follow-up on these patients.

It is important to differentiate the neurogenic sarcoma from the fibrosarcoma since the neurogenic sarcoma is usually characterized by local recurrence and infiltration, and does not produce distant metastases.

There were ten verified cases of fibrosarcoma in our group. One patient is alive nine years following operation and irradiation and is free of recurrence. One patient is alive nineteen years after the primary operation but

SARCOMA OF SOFT TISSUE

Type	Total No.	Dead	Living	Living—Recurrence	Untraced
Fibrosarcoma	10	6	1	1	2
Neurogenic Sarcoma	4	.	1	2	1
Myxosarcoma	2	1	.	.	1
Liposarcoma	2	.	1	.	1
Rhabdomyosarcoma	1	.	1	.	
Osteochondromyxosarcoma	1	.	1	.	.
Synovial Cell Sarcoma	1	1	.	.	.
Kaposi Sarcoma	2	.	.	.	2
Undetermined Histogenesis	2	2	.	.	.
Total	25	10	5	3	7

has local recurrences. Two are untraced and six others are dead.

Only one patient, a white female, is well and free of recurrence. She had a tumor of the rectus sheath. The next patient, a white male, is alive with local recurrences nineteen years after excision of the primary lesion which was a fibrosarcoma of the skin on the back. One patient, a white female who had had a mastectomy performed for fibrosarcoma had numerous local recurrences in the intervening years and died from lung metastasis eleven years after the primary lesion was excised. The next patient's history is given in detail since it illustrates a problem in the management of massive fibro-sarcoma.

R. F., aged 21, had a large mass in the right thigh for about one year. On June 16, 1933, a needle punch biopsy showed fibro-sarcoma. Intensive preliminary roentgen therapy was administered to the tumor. The tumor then diminished to one-third its original size. Two months following the onset of the therapy the mass was excised locally. Eight months later there was local recurrence and fifteen months after the operation the patient died from lung metastases. This was a tumor of high malignancy and because of its size and location, the possibility of amputation, rather than local excision, should have been considered.

The next frequent group was the neurogenic sarcoma. This is a locally recurrent, radio-resistant, and usually slow-growing tumor. We have had four of these in our series. One patient is untraced following transfer to another hospital for recurrence. Two patients are alive following multiple operations for recurrences, and one patient, who had an amputation, is at present well, without recurrence, for one year.

An example of this type of tumor was found in a girl of seventeen, who had had a mass on the instep of the right foot for about four years. There was a gradual increase in size and the tumor was locally excised on July 5, 1944. The first diagnosis was that of a benign fibroma. Subsequently, there was an infiltrating recurrence which was much more cellular than the primary lesion and could not be excised completely. An amputation of the lower third of the leg was done on April 14, 1946.

The myxosarcomata grow rapidly, have a high rate of recurrence and metastasize. There were two in this series, one was untraced, and one died of metastases.

A thirty-nine year old white male, first noted a tumor of his thigh eight months previous to admission on March 24, 1933. At first it was about the size of an egg, but on admission, the tumor mass measured 13 x 15 x 17 centimeters, and was infiltrating in character. Biopsy showed myxosarcoma. The tumor was first treated by roentgen therapy. A dose of 5200 roentgens was administered. As a result of this intensive therapy, the tumor shrank fifteen per cent. On November 26, 1933, the lesion was locally excised at Bellevue Hospital. There was rapid local recurrence which could not be controlled by roentgen or radium therapy and he died in May of 1935, from lung metastases. Would this patient also have had a more favorable prognosis if radical amputation were performed? In evaluating this case report, it is our impression, now, that the tumor, histologically, was too malignant and clinically too extensive to benefit from local excision.

The next case report is rather interesting because of the relationship to trauma which is frequently reported with soft tissue sarcomata.

A white male aged twenty-two, occupation, laborer and mechanic. His mother died of carcinoma of the cervix. The patient was injured on November 5, 1938, and gives the following history:

While loading a truck, a one hundred pound container slipped and struck the inner part of the left thigh. The next day, he noted soreness and slight swelling but no definite ecchymosis. He was given baking treatments over a period of two weeks. Then he first noted a definite increase in swelling over the injured area. One month after injury, a roentgen examination was made. The roentgenologist diagnosed a "possible ossifying hematoma following injury". Local treatments were continued and the swelling became progressively worse. He was admitted to the Newark Beth Israel Hospital August 28, 1939. On admission, a large mass, almost the size of a football, was noted on the medial side of the middle third of the thigh. The mass was somewhat cystic and contained fresh and old blood inside a lobulated cavity. There was also soft, cauliflower-like tissue. The microscopic diagnosis on the biopsy was reported by Dr. Antopol as synovial sarcoma.

Dr. Furst's report on the roentgen examination was as follows:

> "Examination of the thorax shows numerous metastatic nodules invading both the left and right lung fields. The greatest intensity on the left side. Exposure of the left thigh shows a fairly large malignant neoplastic invasion of the thigh. The infiltration seems to be entirely within the soft structures. No definite osseous connection is demonstrable. Diagnosis: Sarcoma of soft tissue."

Because of the chest involvement, only palliative therapy was considered. This consisted of roentgen therapy to the anterior and posterior thigh. The anterior field received 4000 r units and the posterior field, 2700 r units in air. High voltage x-ray

therapy was instituted on September 12, 1939, and completed November 15, 1939. Following treatment the lesion commenced to shrink. Exposures of the thigh on April 18, 1940, showed a marked decrease in the size of the previously reported neoplastic invasion of the soft structure.

GASTRIC NEOPLASMS

The following seven case reports were presented because of their clinical and pathologic interest.

Case 1. Infiltrating, scirrhous carcinoma. A sixty year old male with a history of vomiting for six months and twenty-five pound weight loss in four months. A mass was felt in the epigastrium. X-ray series revealed a diffusely infiltrating, constricting lesion. At operation we found a scirrhous carcinoma of the lesser curvature of the stomach which infiltrated three-fourths of the circumference of the wall of the stomach, proximally, plus liver and gland metastases. Gastrectomy was performed. His condition is poor, four months following operation.

Comment: This type of infiltrating, scirrhous carcinoma metastasizes early and rapidly. Operation, at best, is palliative.

Case 2. Small, ulcerated carcinoma. This is a fifty-eight year old male with no gastric symptoms. During a medical work-up because of repeated, alternating episodes of constipation and diarrhea, persistent occult blood was found in the stools. Roentgen examination revealed an ulcerated lesion of the stomach. At operation, a small carcinoma of the pylorus of the stomach, without palpable metastases, was found. Subtotal gastrectomy was performed and the patient is alive and well one and one-half years since his operation.

Comment: This carcinoma is similar in type to the one in case 1, but is smaller and presents minimal infiltration. The prognosis is good because of early discovery.

Case 3. Small, bleeding carcinoma. A 53-year old male was admitted for the third time, in shock following a gastric hemorrhage. On first admission, nine months ago, x-ray examination revealed no gastric pathology. On second admission, four months ago (because of gastric hemorrhages followed by tarry stools) surgical intervention for the control of bleeding revealed a hemorrhagic mucosal polyp which was removed. Four months later, he was readmitted in shock following massive gastric hemorrhage. Additional x-ray examinations still revealed no evidence of gastric malignancy. At the second operation, a small scirrhous carcinoma of the upper portion of the lesser curvature of the stomach, with massive bleeding and without palpable metastases was found. Subtotal resection of the stomach was performed. The patient is alive and well one and a half years since the last operation.

Comment: Gastric mucosal polyps and carcinoma of the stomach are not infrequently present at the same time. The presence of this benign lesion should warn of the possibility of a concurrent or subsequent gastric carcinoma. Thus, the carcinoma may be discovered early. The massive hemorrhage seen in this case is unusual.

Case 4. Bulky, fungating carcinoma. A 71-year old male gave a two month history of weakness, anorexia, and weight loss, and a twenty-nine year history of "stomach ulcer". A firm mass was felt in the left upper quadrant and occult blood was found in the stools. On x-ray examination, a malignancy of the stomach was reported. The patient refused operation and was discharged. He was readmitted three months later, having become progressively worse in the interim. On his last admission, he was described as poorly nourished and had pitting edema of the left lower extremity. On laparotomy, a bulky, fungating mass was found growing into the lumen of the stomach. There were no palpable metastases or adhesions. The patient's condition, however, did not permit gastrectomy. He died eight days later. At autopsy no metastasis was found. A large pulmonary embolus had caused the death of the patient.

Comment: As a group, fungating carcinomata growing into the lumen of the stomach have a far better prognosis than even the small, infiltrating carcinoma. In a case like this, with no adhesions and no known metastases, had the patient permitted operation on his first admission, the prognosis would have been favorable, despite the large size of the carcinoma.

Case 5. Fungating carcinoma. A 42-year old male complained of nausea, anorexia, and epigastric pain of twelve months' duration. There was a firm mass five centimeters in diameter to the left of the umbilicus. Roentgen examination was suggestive of an intra-gastric mass. When the patient was explored, a carcinoma of the lesser curvature (which infiltrated the mesocolon and the serosa of the transverse colon) was found. There were also metastases to the regional lymph nodes. A high gastric resection, partial transverse colectomy, and ilio-colostomy were done. The patient died eight months post-operatively.

Comment: Despite the lymph gland metastases, an extensive resection is still indicated in this type of neoplasm. Fungating carcinoma usually metastasizes late and therefore, the

disease may not progress rapidly after the evident lesions are removed. The operation also serves to alleviate the symptoms.

Case 6. Hodgkins lymphogranuloma. A 58-year old male had epigastric pain for nine months, relieved for only a few minutes by food. There had been tarry stools and slight weight loss. Roentgen examinations by three different radiologists were all reported as showing a malignancy of the stomach. At operation, a posterior perforating malignancy of the stomach was found, which was adherent to the pancreas. A gastric resection was performed, and following pathologic examination, a report of Hodgkins lymphogranuloma was submitted. The patient was referred for post-operative radiation therapy and nine months following operation was free of recurrence.

Comment: The prognosis in Hodgkins disease localized in the stomach is usually more favorable than that in the generalized type.

Case 7. Lymphosarcoma of the stomach. A 61-year old male complained of increasing epigrastric pain and vomiting for six months. Physical examination revealed epigastric tenderness, slightly enlarged liver, and auricular fibrillation. Roentgen examination showed a malignant stomach lesion. There was strongly positive occult blood in the stool. At operation, a gastric neoplasm, infiltrating the greater and lesser omentum (but without palpable liver metastases) was found. A subtotal gastric resection was performed. Auricular fibrillation continued and the patient went into heart failure and died post-operatively.

Comment: Lymphosarcoma of the stomach may be very radio-sensitive. In administering radiation therapy, use caution, since rapid regression of the tumor has resulted in perforation of the stomach wall.

In these cases symptoms range in duration from two to twelve months. In one case, there were no symptoms referable to the stomach. Ages range from forty-two to seventy-one years, with five of the seven cases between fifty-three and sixty-one years old. All patients in this series were male. Gastric resection was performed in all but the oldest patient. His condition did not warrant gastrectomy. One of the seven cases examined radiologically had negative findings.

To round out the picture, it is of interest to mention the kind of gastric neoplasm in which patients go to physicians for complaints other than those referable to the gastro-intestinal tract. This group has been fully discussed by Jarcho,[1] who designates them as "Diffusely Infiltrative Carcinoma". The lesion in the stomach is often inconspicuous, and at times difficult to locate even in the opened specimen. The patient's complaints may be pulmonary (dyspnea, cyanosis, and tachypnea). The pulmonary symptoms are due to "lymphangitic carcinosis" of the lung. Anemia and bleeding tendencies may be manifested because of bone marrow involvement; and the ovarian enlargement may be presented because of metastases to those organs. When the patients appear before the physician, metastatic phenomena already have occurred, the prognosis is hopeless, and only palliative measures can be instituted. To illustrate this variety of carcinoma of the stomach, a case of a thirty-five year old female complaining of left lumbar pain of two months' duration is presented.

The pain had become increasingly worse and was occasionally accompanied by vomiting. The only relevant physical finding was tenderness to the left of the umbilicus. The patient was markedly anemic, and the differential leucocyte count showed a shift to the left. X-ray series revealed a duodenal ulcer. Because of evidence of internal bleeding, a laparotomy was performed. At operation, metastatic carcinoma of the right ovary was found. Several hours post-operatively, the patient complained of very intense chest pain, gasped, and expired. At autopsy we found a small, flat, ulcerated carcinoma of the stomach, with "lymphangitic carcinosis" of the lung, and metastases to the liver, vertebra, and thoracic lymph nodes.

CARCINOMA OF THE GALL-BLADDER

A series of twenty-six cases of carcinoma of the gall-bladder gathered during a period of ten years between 1936 and 1946, was presented. During this time, 1645 operations upon the gall-bladder were performed at the Newark Beth Israel Hospital. Both types of operations (cholescystostomy and cholecystectomy) are recorded in this group. Twenty-six suffered primarily from carcinoma of the gall-bladder. Average age was fifty-nine, the youngest thirty-four, and oldest seventy-eight. All had cholelithiasis. Twenty-five of these patients had no previous gall-bladder operation. One was operated upon for gall stones

1. Jarcho, Saul: Archives of Pathology, 22:674 (July, 1936).

eighteen years ago. A cholecystostomy was done at that time.

Duration of illness varied from several days to thirty years. Some patients gave a history of gall-bladder colic lasting anywhere between two and thirty years. Others gave a history of mild jaundice lasting several days. In eight cases there was a history of severe jaundice lasting several days to several weeks.

The current literature shows a reduction in the incidence of gall-bladder carcinoma as compared with the earlier reports. The average ratio of cases reported varies between half of one per cent to 1.7 per cent.

The role which gall stones play in the cause of carcinoma of the gall-bladder was discussed. Since there is no exact information as to the causative factor we must look upon the frequency of gall stones in association with carcinoma as one of the most likely contributing factors to this disease.

It was Dr. Danzis' opinion, based upon the clinical findings in the cases which he reported (and also through his review of a much larger group gathered from the literature in which gall stones were also the predominant finding) that early removal of gall stones may act as a prophylactic measure in the prevention of carcinoma of that organ.

It was stressed by Dr. Danzis that the preoperative diagnosis of primary carcinoma of the gall-bladder is rarely made. In twenty-six cases admitted to the Newark Beth Israel Hospital, the admitting diagnosis was either cholecystitis, cholecystolithiasis or empyema. The true condition was not suspected at the time of admission. In 60 per cent of the cases, the diagnosis was made by the pathologist.

Sixteen of these patients died within a year after leaving the hospital. Eight died in the hospital. One patient is alive five years after her operation for cholecystitis with cholelithiasis. The diagnosis had been established several days before admission. The present onset was very acute. A cholecystostomy and biopsy were done. The microscopic examination showed infiltrating adenocarcinoma and acute cholecystitis. Dr. Antopol reviewed the slides and assured us that the diagnosis of carcinoma is correct. One patient was operated upon six months ago and is still alive. The ultimate result is doubtful, consequently, we can consider only one case as a five year cure.

Dr. Danzis stressed the importance of biopsies of the gall-bladder when cholecystostomies are done in order to eliminate the possibility of diagnostic errors. It was pointed out that in all cases of carcinoma of gall-bladder with beginning involvement of extrahepatic ducts, cholecystectomy is not indicated. No benefit will be derived from such an operation. It was also stressed that a more careful review of the operative findings, with that of the pathologist's, should be done so that errors in diagnosis may be avoided.

The full transcript of Dr. Danzis' paper will be published in an early issue of THE JOURNAL.

201 Lyons Avenue

CANCER IS EVERYBODY'S PROBLEM

"The cancer problem from the public's point of view should be everybody's problem," writes John J. Morton, University of Rochester School of Medicine, in the December 13 *Journal of the American Medical Association.*

Dr. Morton's article is the first of a series on various aspects of cancer which will appear in *The Journal.* When complete, the series will be published in book form.

The articles are designed to aid the general practitioner in the early diagnosis of cancer and to guide him in the selection of the correct technic of treatment. But the public has work to do as well as the physician.

"The public must become cancer conscious," says Morton. "It must approach this problem in a rational manner. The physicians of America have launched a crusade to learn more about cancer. They need the help of the public for education, for service and for research. They need the intelligent cooperation of everybody.

"The people of the country must see to it that their physicians examine them for cancer."

HIGHLIGHTS FROM HEADQUARTERS

JAMES E. BRYAN, Executive Officer

In collaboration with the medical societies of the respective counties, The Medical Society of New Jersey is now presenting regular fifteen-minute weekly programs over radio stations in Trenton, Newark, Paterson, Jersey City, Camden, Bridgeton, Atlantic City, and Asbury Park. The material is supplied by the American Medical Association and arrangements for local broadcasting have been made by the Woman's Auxiliaries of the Medical Societies of the counties in which the stations are located. A schedule of these broadcasts giving the names of the programs, the days and hours, and the call-letters of the cooperating broadcasting stations appears on page 87 in this JOURNAL.

AIDING OUR VOLUNTARY HOSPITALS

Strenuous efforts are being made to implement a resolution adopted by the Board of Trustees of The Medical Society of New Jersey on November 16, 1947. In this resolution, The Medical Society invited the attention of the Governor and the legislature to the need of additional revenue to meet the alarming growth in the deficits of the voluntary hospitals throughout the state. It was proposed that these funds be used to enable the counties and municipalities to pay the voluntary hospital full cost of hospital care given indigent and medically indigent persons; also, through the medium of Rutgers University, to provide subsidies for hospitals that maintain nurses training schools; and third, that additional funds be made available to the Department of Institutions and Agencies for the care and treatment of patients for whom that Department is responsible.

The *per diem* allowances paid to voluntary hospitals by Departments of Welfare throughout the state for hospital services rendered welfare clients and their families now represents not more than 60 to 70 per cent of the actual *per diem* cost to the voluntary hospital. It is not contemplated that the state should subsidize deficits of voluntary hospitals, but merely that counties and local communities should be enabled to pay the hospital the full cost of the care given patients whose care is the responsibility of the community.

These training schools now provide nurses not merely for hospitals but for health departments, welfare agencies, schools, industry, visiting nurse associations, and the Veterans Administration. Nursing education is thus a community responsibility and should be recognized as such.

While these proposals would require the state to raise some additional funds, they will produce more and better hospital and nursing service; they will help to perfect and improve our voluntary hospital system; and they will relieve self-supporting patients in some measure of an almost insupportable burden, much of which is properly a charge against the community at large.

Medicine enters this picture as a friend of the private hospital and the private patient. It asks nothing for itself, but it recognizes that the fate of the voluntary medical system in the United States is inextricably tied to the fate of the voluntary hospital system. Only as we safeguard the one can we hope to preserve the other.

The Society's resolution was transmitted to the Governor and all members of the legislature as well as to other interested agencies. The response was encouraging but the universal question is raised, "Where do we get the money?" On this point, representatives of The Medical Society have repeatedly suggested that physicians would be sympathetic to special taxes on luxuries if they were necessary to produce the revenue required. Obviously the deficits of the voluntary hospitals, (which approached two and a half millions of dollars in 1947) must somehow be paid. These deficits would largely disappear if all the agencies which have assumed financial responsibility for hospital care of various types of patients were to pay the full cost of such care.

Considerable impetus has been lent these proposals by the New Jersey Health Congress which devoted its entire meeting on January 21 to a discussion of them. Provision has been made for establishment of a special committee of the Congress to meet at once with the various official and voluntary agencies concerned and to prepare specific plans for action, legislative or otherwise. These are to be presented within the next few weeks to all member agencies of the Health Congress for their approval and support.

The Medical Society's initiative has been especially welcomed by the New Jersey Hospital Association, which for several months

has been carrying on an energetic campaign to persuade Boards of Freeholders wherever possible to increase their allowances to hospitals for the care of the indigent patients. In some instances the Boards of Freeholders have indicated they would gladly appropriate more funds if statutory limitations upon their appropriating powers could be relaxed and if additional state funds could be made available.

"HEALTH HINTS" FOR SCHOOL CHILDREN

The Board of Trustees of the Society recently adopted a recommendation of the Welfare Committee that our weekly health information service for newspapers and house organs throughout the state be offered to public schools for use in school papers and in classes on hygiene and general science. With the ready consent of the State Department of Education, this service was offered through the county superintendents of schools to the supervising principals in all areas. Beginning in March, "Health Hints", our weekly column of health information, will be distributed to nearly two thousand school administrators and teachers. This is another instance in which your State Society is attempting to play the ideal role of collective physician to the community.

"HEALTH HINTS" IN THE NEWSPAPERS

Beginning March 1, the component county medical societies have been invited by The Medical Society of New Jersey to join with it in providing our "Health Hints" column for weekly and daily newspapers in their respective county areas.

This health educational service, which for some time has been made available to newspapers under the sole sponsorship of the State Society, will henceforth reach the public under the combined sponsorship of the State and county societies in each area, wherever the county society consents to this arrangement. Individual members are requested to watch for this column in their daily and weekly newspapers. If it is not being used, call attention of local editors to the availability of this service. Frequently an expression of interest on the part of a reader or two is all that is needed to produce the desired results.

WHAT IS PUBLIC RELATIONS?

Dr. George F. Lull, Secretary and General Manager of the American Medical Association, said recently that the best public relations consists of 80 per cent doing and 20 per cent publicity. Some experts put it even higher—insisting that 90 per cent of a good public relations program is a program of public service and 10 per cent is telling the people about it. After all, you can no more conceal a public service from public notice than you can hide a bandaged nose at a tea party.

These concepts of public relations are a far cry from the tricks and stunts of the old press-agentry days. Just as medicine as a science has long since emerged from its witch doctor and voodoo period, so public relations as a calling has left behind the hocus-pocus stage when it was thought possible to make a silk purse out of a sow's ear by resort to various more or less hysterical tricks and dodges.

If good public relations be measured in terms of public service and accomplishment, then The Medical Society of New Jersey has the stuff of which good public relations are made. Your Society has a policy and, in most instances, a practical program for the solution of nearly every major problem facing medicine either as a scientific profession or as a social group. The Society is alert equally to the challenges and the opportunities that confront it.

Having shown itself worthy of leadership and willing to assume it, The Medical Society of New Jersey is often and eagerly consulted for advice and guidance in the formulation of every program in which it has any legitimate interest. Most of the cooperating agencies in the community, as well as other professional groups, are aware of and responsive to the progressive attitude The Medical Society of New Jersey has displayed in all matters of joint concern.

Some challenging opportunities remain to be exploited in telling the public about the policies and purposes of the Society. Through its developing public relations programs these opportunities will be met. Every medium of public expression is to be used to the utmost in an effort to create that understanding and good will among the general public which The Medical Society of New Jersey is earning for itself.

One element in all this is of direct concern to each individual doctor. The thought we have in mind was so well expressed by the editor of "Medical Annals of the District of Columbia" recently, that we will let him set forth this thought for us: "There is no substitute for good medical care provided by competent and considerate physicians. This of itself will do more than anything else to instill confidence and create good will. . . It should require no public relations counsel to enlighten physicians on how to obtain public good will. All that is required is common sense."

STATE ACTIVITIES

A.M.A. HOUSE OF DELEGATES

REPORT OF INTERIM MEETING

The interim meeting of the House of Delegates of the A.M.A. was held in Cleveland, January 5 and 6, 1948. The complete delegation from New Jersey, comprising Doctors Lewis, Londrigan, Read, Costello, and Hurff, attended the meeting accompanied by Dr. Scott and Mr. Bryan. Mr. Don Smith of the Newark Evening *News* also accompanied the party to Cleveland.

In the organization of the House of Delegates, Dr. Lewis served as chairman of the Reference Committee on Rules and Order of Business; Dr. Londrigan served as chairman of the tellers.

Two resolutions were presented by the New Jersey delegates. The first called attention to the unsatisfactory distribution of interns and asserted the desirability of requiring a year's general rotating internship before a physician begins specialist training. This resolution also proposed appointment by the speaker of the House of Delegates of a Committee of five members of the House, including two general practitioners, to study this matter and to report at the next session of the House in June. This resolution was introduced by Dr. Read and referred to the Reference Committee on Medical Education. The resolution stimulated much interesting and lively discussion in the hearing before the Reference Committee. Pressure was brought to bear by some members of the Board of Trustees of the A.M.A. and of the Council on Medical Education to have this referred to the Council on Medical Education and Hospitals rather than to have a special committee appointed by the House. Ultimately this resolution was consolidated with a similar one from Ohio and passed in a slightly amended form by the House after considerable discussion. All essential points proposed by the New Jersey Delegates were intact in the finally accepted resolution.

The second resolution introduced by Dr. Lewis related to S. 545—Taft Bill, and urged that this act be amended to provide that federal grants-in-aid be made available only to states which prove a definite need for federal subsidy for the purposes of that act. This resolution was referred to the Reference Committee on Legislation and Public Relations (Dr. Bates of Pennsylvania, Chairman). The resolution was adversely reported on the grounds that it "was inexpedient and might alienate valuable political support at this time". Ultimately the Reference Committee's action was amended to provide that the House take no action at all on this resolution, since to reject it was considered tantamount to a rejection of the basic policy of the A.M.A. under which this resolution was formulated in the first place.

Other high lights of the interim session were as follows:

The House selected Dr. Sudan of Denver as the outstanding general practitioner to receive the first award of this kind.

President Bortz of the A.M.A. emphasized the work of the A.M.A. bringing about a closer affiliation with interns and medical students. He stressed, however, that this must eventually be implemented on a state basis rather than nationally. Dr. Bortz announced the publication of a new handbook by the A.M.A. discussing its activities and services. Dr. Bortz commended the Woman's Auxiliary for its work and spoke in terms reminiscent of those used by Dr. Schaaf of the value of the Woman's Auxiliary as a public relations agency for the profession.

Dr. Bortz spoke of the overwhelming importance of prompt study of protection against the medical effects of a possible atomic attack. In this connection, he emphasized the revolutionary challenge of the development of radioactive isotopes in medical work in the future.

Dr. Henderson, Chairman of the Board of Trustees, reported a $70,000 deficit in A.M.A. operations in 1947 and prophesied that the 1948 deficit would probably exceed $100,000. He detailed the increased cost of operations, especially in the printing of the *Journal*. The House adopted a proposal to increase from eight to twelve dollars the annual dues of fellows and the annual subscription to the *Journal*.

The House adopted a resolution establishing a permanent conference committee on nursing problems to sit with similar committees of the American Hospital and Nursing Associations.

The National Multiple Sclerosis Society and its program were indorsed by the House of Delegates.

The House adopted a new set of rules and two new orders of business, one for the interim sessions, the other for the annual sessions, with certain revisions proposed by the reference committee of which Dr. Lewis was chairman.

A resolution was introduced by the Utah State Medical Association protesting the exploitation of professional medical services in the field of radiology, pathology, and anesthesiology by certain hospitals, urging that this practice be condemned and resolving that the House of Delegates instruct the Board of Trustees of the A.M.A. "to direct the Council on Medical Education and Hospitals to refuse approval for training of residents and interns of any hospitals exploiting professional medical services". This resolution was referred to a new continuing Committee on the Practice of Medicine by Hospitals to be set up soon. It was also suggested that all previous actions of the House of Delegates on this subject be re-studied; that the four specialties be recognized as part of the practice of medicine; that all specialists on the staff of a hospital be under the authority of the medical board; that all rules and contracts with staff members be approved by the medical staff; and that the new continuing committee hold conferences with the hospital associations and specialty societies and interested groups and report recommendations for corrective or disciplinary action to the judicial council. Several other resolutions on this same subject were referred to this new study committee.

A report was received from a committee on nursing headed by Dr. Murdoch of Connecticut and its objectives were approved as follows: (1) to stimulate recruitment for nurses' training schools; (2) to develop the practical nurse with one year of training; (3) to include nurses under social security benefits and give them benefits of retirement plans, medical care and hospitalization insurance; and (4) to establish the continuing conference committee referred to above.

A resolution was approved providing for emphatic recognition by the A.M.A. of the value of more extensive use of x-ray in the examination of school children and teachers and putting the A.M.A. on record as seeking to further all efforts to promote this type of health service in the schools.

A resolution which would have limited the tenure of membership in the House of Delegates was disapproved on the ground that this is a function of the state societies.

A resolution that would have established a mechanism for geographic representation on the A.M.A. Board of Trustees was also disapproved.

California recommended that the A.M.A. withdraw its approval of the Red Cross National Blood Donor Program. This was rejected in favor of a resolution reiterating this approval provided that the responsibility for technical medical details of this program be clearly confided in the local or state medical society and that a permanent A.M.A. committee be established to coordinate these programs.

The Trustees introduced Mr. Theodore R. Sills of Chicago, the new public relations consultant to the A.M.A., and Mr. Lawrence W. Rember, the new administrative assistant in charge of public relations work of the A.M.A.

Reports were received both from the Trustees and from Dr. Routley of the Canadian Medical Association on the newly organized World Health Association, whose permanent office is to be established in New York in March 1948.

MEDICAL LECTURES AT LYONS

Members of The Medical Society of New Jersey are invited to attend and participate in a series of Saturday morning lectures at the VA Hospital in Lyons. These talks begin at 8:30 a. m. An all-star program has been arranged and includes the following:

February 14, Professor Carroll Pratt of Princeton, *Psychology of Creative Personality.*

February 21, Professor Hadley Cantril of Princeton, *Psychology of Public Opinion.*

February 28, Professor Cantril will continue his talk on the *Psychology of Public Opinion.*

March 6, Professor C. J. Warden of Columbia University, *Experimental Psychoneurosis.*

March 13, Albert Deutsch, columnist and lecturer, *History of Psychiatry in America.*

March 20, Albert Deutsch, *Social and Economic Aspects of Psychiatry.*

Each Saturday at 10 a. m. Professor Stephen P. Jewett, and members of his staff will speak on various phases of *Psychosomatic Medicine* and present illustrative case material. All physicians are invited.

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Chairman Nutrition Committee

When should we discontinue vitamin D in infants as a prophylaxis against rickets?

Continue the vitamin until the child is 14 years old. In one recent research project, almost 50 per cent of children from 2 to 14 years of age were found to have rickets even though many of them had had Vitamin D in infancy.

Is there any difference in the nutritive value of diets made from dehydrated foods compared with those prepared from fresh foods?

They are equally nutritious. Protein and fat are each digested in the diets made from dehydrated and fresh foods. They compare favorably in urinary nitrogen, stool bulk, weight retention, and acceptability.

Is fish as nutritious as meat?

Some fish are good nutrients and some are not so good. One of the best is swordfish. It is a complete protein. It contains the ten amino acids essential for human nutrition. It is easily digestible and has a biologic value. It has some fat but no appreciable amount of carbohydrate. The Vitamin A content of swordfish is high. Its thiamine and riboflavin content are about half that of beef and chicken. The niacin content is much higher than that of beef or ham and about the same as chicken or tuna fish.

What foods minimize the action of vitamins?

Fats may reduce the production of riboflavin in the gastrointestinal tract.

Please explain the Vitamin M group and gastrointestinal absorption?

It was recently reported that the response of patients in six relapses of sprue had been followed after therapy with the Vitamin M group (pteroylglutamates) only. Satisfactory hematologic remissions have been accompanied by the following clinical evidences: improved gastrointestinal absorption, relief of glossitis, cessation of diarrhea, and chemical changes interpreted as indicating improved absorption of glucose and of fat-soluble substances from the alimentary tract. These chemical evidences were: (a) a rapid return toward normal of the flat glucose tolerance curves characteristic of sprue; (b) a more gradual return toward normal of the Vitamin A and tocopherol tolerance curves; (c) a rise in serum carotene and tocopherol levels; and (d) a decrease in the prothrombin time. Less extensive data indicate that the stool fat content decreased and that the roentgenologic pattern returned slowly toward normal.

Which cereals are preferred for children?

Rice shows a higher carbohydrate content than wheat and oat cereals and contains less indigestible carbohydrate.

VA BILLS — SUBMIT THEM WITHIN THIRTY DAYS

Physicians who treat veterans on a fee basis are reminded of the importance of submitting their bills promptly. Local VA offices are still waiting for bills covering services rendered many months ago. The federal government deposits money to the credit of its field offices at quarterly intervals, and unused funds revert to Washington. If it is not mailed in promptly, a bill may reach the VA office after the funds allocated to it have been returned. This enormously complicates the bill-paying problem, and is one reason VA payments seem to be so slow in coming through. If every physician would submit the bill within thirty days of rendering an authorized service, there would be gratifying speed-up in payment.

RADIO PROGRAMS OF STATE AND COUNTY SOCIETIES IN NEW JERSEY

Eight local radio stations are presenting various program series that have been made available to The Medical Society of New Jersey and its component county societies by the American Medical Association.

Arrangements in each case have been made by the Woman's Auxiliary to the local county medical society, in cooperation with the Public Relations Committee of The Medical Society of New Jersey.

Arrangements for a series to be presented over WCTC in New Brunswick are pending.

Members of the county societies and their auxiliaries are requested to interest their lay friends in listening to these programs.

James E. Bryan, Executive Officer.

Present schedule is as follows:

Station	*City and County*	*Time*	*Program Series*
WFPG	Atlantic City (Atlantic County)	Mondays 10:00—10:15 A. M.	"Before the Doctor Comes"
WCAM	Camden (Camden County)	Fridays 11:00—11:15 P. M.	"Live—and Like It!"
WSNJ	Bridgeton (Cumberland County)	Wednesdays 11:45—12:00 A. M.	"Live—and Like It!"
WAAT	Newark (Essex County)	Fridays 8:30— 8:45 P. M.	"Time Out"
WHOM	Jersey City (Hudson County)	Fridays 6:00— 6:15 A. M.	"Keeping Your Baby Well"
WTTM	Trenton (Mercer County)	Mondays 9:15— 9:30 A. M.	"Medicine Serves America"
WCAP	Asbury Park (Monmouth County)	Saturdays 10:30—10:45 A. M.	"Melody of Life"
WPAT	Paterson (Passaic County)	Wednesdays 2:00— 2:15 P. M.	"Medicine Serves America"

NAVY COMMISSIONS FOR PHYSICIANS

Recent legislation makes it possible now for civilian doctors to become commissioned officers in the regular Navy, provided they meet the professional and physical qualifications. For the first time, the law does away with the age limitation of thirty-two years and permits doctors in civilian practice to enter the Navy and be commissioned with the rank up to and including Captain. The law considers all strata of the medical profession, including interns, residents, reserves, former medical officers, and present practicing physicians.

To make application, a doctor must be a citizen of the United States, a graduate from a Class "A" medical school and have served at least one year's internship in an approved hospital. Candidates are judged on a number of qualifications including teaching connections, years of professional or scientific practice, board diplomas, hospital or laboratory connections, a statement of military service, etc.

Allocation of rank to successful candidates depends upon their academic age, professional standing, and federal experience. Newly commissioned officers will be integrated in line with medical officers of the regular Navy and assigned running mates accordingly. They will be eligible for promotion along with their fellow officers of equal rank.

This law offers a fine opportunity for civilian doctors to make a career in the regular Navy and to enjoy its professional advantages as well as its retirement benefits. Doctors interested in such a career should write to the Bureau of Naval Personnel, via the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

PSYCHIATRIC RESOURCES — A CORRECTION

In The JOURNAL of The Medical Society of New Jersey (November 1947, page 465) there appeared a brief summary of *Hospital and Public Health Resources in New Jersey,* published by the Department of Institutions and Agencies.

In one paragraph, referring to the facilities of New Jersey for the care of mental patients, it is stated:

> On the other hand, New Jersey is well ahead of most states in the provision of out-patient mental clinics. The National Mental Hygiene program calls for one such clinic for each 100,000 of the general population. On this basis, our state should have 41 mental hygiene clinics. The report lists a total of seventy, of which 41 are operated by the state, and 29 by counties or municipalities.

The Source Book actually reported that the state operates some 26 psychiatric and psychologic traveling clinics in various communities. However, in the operation of these clinics the state has, at the present time, a little more than three "clinic teams". A "clinic team" comprises a full time psychiatrist, a full time psychologist, and two full time psychiatric social workers. The federal yardstick calls for one complete "clinic team" for each 100,000 of the population and not merely for an occasional traveling clinic. Furthermore, practically all of the non-state clinics operate on a part-time basis, some for only one or one-half day per week. Also, few of these non-state clinics have personnel in all three categories listed above. Hence, a truer estimate of the existing situation would have stated that the established needs for mental hygiene clinics in New Jersey are met at present to the extent of only about 10 per cent.

We appreciate the courtesy extended by the Editor of this JOURNAL in permitting us to correct this misinterpretation of the Report by the Department of Institutions and Agencies.

JAMES E. BRYAN, Executive Officer,
The Medical Society of New Jersey.

OBITUARIES

DR. EDGAR M. BRAUN

Dr. Edgar M. Braun of Irvington, died in East Orange, on December 26, 1947, of a heart attack. He was born in Newark in 1909, and for the last year and a half his office had been located in Newark. In 1932 Dr. Braun was graduated from Brown University, cum laude. He received his medical degree in 1938 from Duke University School of Medicine. He practiced in Plainfield for a year before entering the army in 1944. Dr. Braun served as a captain at the general hospital at Fort Knox.

DR. WILLIAM M. BRIEN

Dr. William M. Brien, first mayor of West Orange, died of a heart attack at his home in Orange on November 19, 1947.

Dr. Brien was born in Jersey City in 1861, and was graduated from New York University Medical School in 1891. He started practice in West Orange and was the town's first health officer, serving from 1893 to 1898. He was appointed deputy county physician in 1918, and served in that capacity until 1927, when he was given the title of assistant medical examiner.

Dr. Brien was chief of the ear service at the Newark Eye and Ear Infirmary for fifteen years and had been connected with the staff there for more than fifty years. He was a veteran of the Spanish War, serving with the Second New Jersey Volunteers with the rank of assistant surgeon.

DR. HARRY R. J. KELLY

Dr. Harry R. J. Kelly of Weehawken, died on October 17, 1947, in St. Vincent's Hospital, New York City, of a coronary thrombosis. Dr. Kelly, a practitioner in North Hudson since 1935, was a member of the staff of St. Vincent's, North Hudson Hospital in Weehawken and was chief of service at St. Mary's Hospital, Hoboken.

Born in New York City in 1899, Dr. Kelly moved to Weehawken at an early age. He was graduated from the University of Virginia Department of Medicine in 1931 and specialized in internal medicine. He served in both world wars and as assistant chief of the staff of Letterman General Hospital in San Francisco, received several citations for his work with the wounded of the Pacific area.

DR JOSEPH TOAL

Dr. Joseph Toal, a practicing physician in Ridgefield since 1928, died on October 19, 1947, in Englewood Hospital of a heart ailment. Born in Glasgow, Scotland, in 1891, Dr. Toal had been in the United States for 40 years. He was graduated from Syracuse University College of Medicine in 1927. Dr. Toal served his internship at the Post Graduate Hospital in New York City. He was on the staff of Englewood Hospital and served as head of the Out-Patient Department and Clinic for a number of years.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

FIND THE MISSING MILLION

During February, the American Social Hygiene Association makes its report to the people of the United States and asks for continued support, as do social hygiene associations throughout the country. Many other organizations hold meetings during February, in a nation-wide campaign to promote positive local hygiene programs and the education of young people for marriage and family life, which are the broad objectives of the social hygiene movement.

The slogan for Social Hygiene Day 1948, emphasizes the medical and public health aspects of the movement. "Find the Missing Million" refers to the 155,000 cases of early infectious syphilis and 825,000 new cases of gonorrhea in the United States which, each year, fail to come to treatment. In this vast reservoir of infection, new cases have their origin. Every patient who comes to treatment should be questioned about the source of his infection and the persons he may have exposed to infection. To assist physicians in interviewing patients for contact information, and to investigate such information, the State Department of Health has public health nurses stationed in various parts of the state. Physicians are urged to use the services of these nurses.

PENICILLIN TREATMENT

Penicillin treatment without cost to the patient is available for cases of syphilis of less than one year's duration. The patient stays for five or six days at a local general hospital, or at Medical Center, Jersey City, during which time a total dosage of 2,400,000 units of penicillin is administered. Call your local Health Officer, Public Health Nurse, hospital, or the State Department of Health (Trenton 2-2131, Ext. 704) for further information and application forms, if you are not supplied.

The treatment of syphilis with POB (penicillin in oil and beeswax) is a satisfactory procedure for the ambulatory patient who can afford the cost of this preparation. The suggested dosage for early cases of syphilis is a single injection of 600,000 units daily for eight to ten days.

Most cases of gonorrhea respond to a single injection of 300,000 units of POB or to 200,000 units of penicillin in aqueous solution, which is usually administered in two or three injections over a two hour period.

Physicians interested in the broad aspects of social hygiene will be glad to know that the venereal disease committee of The Medical Society of New Jersey is planning a session on sex education and delinquency for the Annual Meeting in April 1948.

FLUORINATION OF WATER SUPPLIES

In New Jersey, 95 per cent of the population are served by 270 public water supplies. During the past two fiscal years, 449 examinations of these supplies have been made for fluorine content. All but 8 per cent have a fluorine content of 0.25 ppm or less, while only 4 per cent of the public supplies had sufficient fluorine (1-1½ ppm) accepted as beneficial in the prevention of dental caries, yet not sufficiently high to be productive of dental fluorosis.

The high fluorine area of public water supplies in New Jersey is in communities within a fifteen mile radius of Glassboro, in southwestern New Jersey. Nearly all these communities are in Gloucester County, a roughly rectangular area some 10 miles wide and 30 miles long, extending from the Delaware River on the west to about the middle of the State to the east, where it adjoins Atlantic County. The towns have artesian well supplies 500 to 700 feet deep. On the other hand, many examinations of the water from shallow wells within this area showed the fluorine content to be of the magnitude of 0-0.2 ppm fluorine.

A fluorinated water supply (1 to 2 ppm) will produce the following results as compared to non-fluorinated water (less than 1 part per million):

(A) Six times as many children having no dental caries experience;

(B) 60% lower dental caries experience rate;

(C) 75% decrease in the first permanent molar loss;

(D) 90% reduction in tooth surface caries in upper anterior teeth.

It is recommended that one or two experimental programs adding 1 ppm fluorine to an erstwhile free fluorine water supply be set up in one or two selected communities for the following reasons:

1. The yearly cost is relatively low—9 cents per capita.

2. The dental caries rate is lower among children reared in a community with a communal water supply in 1 ppm fluorine.

3. No injurious concomitants have been revealed from the addition of 1 ppm fluorine to communal water supply.

4. It would be advantageous to citizens of New Jersey if a demonstration study were made. We would be more certain of the results of adding fluorine to a water supply and information about the installation and maintenance would be more readily available to New Jersey authorities.

THE PROBLEM OF THE CHRONICALLY ILL

The term chronic illness is difficult to define. A chronic illness may appear in many forms, mental or physical or combinations of both. It affects persons of all economic classes and of all ages. It is not confined to the aged, nor to the degenerative diseases. Its over-all effect upon the life of the individual and his family depends upon many factors; its cause, its severity, its type, the degree of disability it causes, the usual occupation of the individual and the economic position of the individual or family. The term as used here does not include active tuberculosis or mental diseases requiring institutional care.

As a solution for this complex problem we hear much talk today favoring the construction of special hospitals or additions to our voluntary hospitals, to meet the needs of these unfortunate people. That there is need for additional facilities is apparent, but the need for facilities as extensive as recommended by some is questionable.

The chronically ill patient, who is incapacitated for work, is usually happier in his home surroundings, if the atmosphere of his home is satisfactory and if he is provided with adequate medical care and advice, adequate food and adequate clothing. These requirements, in most cases of such chronic illnesses, can be met in families of adequate income.

The most difficult problem is meeting the needs of the patient in a family of inadequate income. It is true that he may require periods of hospitalization for diagnostic purposes, necessary surgery or the treatment of acute exacerbations. This type of care may be rendered in any general hospital, but this type of patient does not frequently need, or desire, prolonged eleemosynary institutional care.

With hospital construction costs and hospital day costs at new high peaks, and no evidence that the costs will ever be less, it behooves us to consider other means of providing adequate care of the chronically ill person in families of modest or low income.

A distinct contribution to the solution is the City of Newark Medical Plan for the care of persons confined to their homes with illness. This Plan is available, at public expense, to the indigent or to any resident of the City of Newark, who, in the opinion of the Social Service Bureau of the City Board of Health, is unable for financial reasons to provide himself with adequate care. It provides for home medical care by a physician of the patient's choice; x-ray, laboratory and consulting services at Newark Dispensary; and diagnostic studies, surgery or medical care when indicated, by admission to City Hospital or one of our voluntary hospitals.

As of January 1, 1948, home nursing services through the Visiting Nurses' Association are provided. One more type of service is desirable to make the program complete—visiting housekeeping service. With these three types of service—medical, nursing and housekeeping—these chronically ill patients will be provided with the type of care they most desire at less expense to the community than would be incurred by paying the cost of prolonged hospitalization in any type of hospital.

The medical phase of the program is administered by Medical Service Administration from 31 Clinton Street, Newark, which will be glad to answer any questions or provide further information.

NORMAN M. SCOTT, M.D.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held at the Traymore Hotel on January 9, 1948, at 9 p. m. DR. CLARENCE WHIMS, the president, presided. The scientific part of the meeting consisted of a panel on the *Problems of Family Life*. The discussion was led by DR. EARL D. BOND, director of research of the Institute of Pennsylvania Hospital. Dr. Bond explained how the family physician does not simply treat an illness in the family—rather his interest extends into many fields other than medicine such as economic problems, education of the family, etc.

Another speaker was DR. CHARLES H. BRANCH, also of the Institute. Dr. Branch showed that the healthy development of the adult depends upon the healthy development of the child.

MISS DOROTHY HANKINS, of the Philadelphia Child Guidance Clinic, was the next speaker. She explained that just having a child did not make a parent out of a person. There are two groups of parents who will cause family problems to arise. One of these believes that providing food, clothing, discipline, education, etc., for a child is sufficient to develop a normal individual. The second group consists of parents who are well-read and instructed to such an extent that they are self-conscious about what they do so that they do not behave naturally towards their children.

The concluding speaker was PROFESSOR FRANK D. WATSON, head of the department of sociology at Haverford College. Dr. Watson said that the successful family is not one without problems, but one which knows how to solve its problems.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society,* held at Bergen Pines Hospital, Oradell, on the evening of December 9, 1947, was called to order by the president, DR. RUDOLPH C. SCHRETZMANN, at 9:15 p. m.

President Schretzmann extended greetings of the Bergen County Medical Society to the members of the Passaic County Medical Society who travelled from Passaic County to add to the success of this joint meeting.

The following doctors who formed the panel of round table discussion on "Cancer" were introduced by DR. GEORGE W. KNOWLES, Chairman of the Scientific Committee: DR. GEORGE T. PACK, attending surgeon, Memorial Hospital for Cancer and Allied Diseases, New York City, clinical professor of surgery, New York College of Medicine, consultant to the Tumor Clinics of the Hackensack and Paterson General Hospitals; DR. THEODORE R. MILLER, clinical assistant surgeon, Memorial Hospital, New York City, consulting physician, Tumor Clinic, Hackensack Hospital; DR. ROBERT J. BOOHER, assistant surgeon, Memorial Hospital, New York City, consulting physician, Tumor Clinic, Hackensack Hospital; DR. LESLIE R. TABOR, director, Tumor Clinic, Passaic General Hospital; DR. L. S. SNEGIREFF, Medical Director, New Jersey Division of the American Cancer Society; DR. JOHN L. OLPP, member of the Cancer Control Committee of the State Society and member of the Board of Trustees of the New Jersey Division of the American Cancer Society.

Some of the highlights brought out during the question and answer periods were:

1. Testosterone is best used in cases of cancer of breast which metastasize profusely to bone. The estrogens have been found effective in mammary cancers metastasizing to soft tissues. The hormones have been found as effective as radiation in cases in which they *will* work.
2. The radioactive isotopes are still confined to use in research. They have been found of some use in cancers of the thyroid. The nitrogen mustards have found their greatest field of usefulness in the lymphomas and leukemia.
3. The chemical and serological diagnosis of cancer has been pretty well abandoned with the exception of the comparatively new Papanicolou stain. The recent use of Teropterin, etc. ("the new injection treatment") have not shown too much promise.
4. The cancer specialist has nothing in his eyes or hands which the general practitioner does not possess for the early diagnosis of cancer. The great majority of early cancers can be recognized by the general practitioner as easily as by the specialist if he will only look.

Following the question and answer period, Dr. Miller gave a short talk on "Recent Observations on the Work of Cancer in the Clinics of the Scandinavian Countries", and the scientific session was closed with a talk by Dr. Pack on "The Definition of Inoperability of Cancer".

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The first meeting of the *Burlington County Medical Society* for the year 1948, was held on January 8, at the Riverton Country Club.

Dr. Dean LeFavor introduced the speaker of the evening, DR. WILLIAM Y. LEE, associate professor of surgery at Hahnemann College of Medicine, who addressed the Society on "Peritoneoscopy With Interesting Observations". The first part of his talk was a brief history and evolution of the peritoneoscope. The indications for peritoneoscopy are ascites; malignant tumors of the colon, stomach and of the pelvic organs; diseases of the liver, gall bladder and the spleen; abdominal masses; hemoperitoneum; diseases of female adnexa; and anatomical anomalies. There are only three contraindications to this procedure; first, acute intra-abdominal pathoses; second, extensive post operative adhesions; and third, cardiac decompensation. At this point Dr. Lee described the technic of

using the peritoneoscope. He told how air was injected into the peritoneal cavity in order to separate the abdominal wall from the viscera, which is similar to the procedure used by urologists when they use water to distend the urinary bladder during examination. Throughout his talk Dr. Lee showed slides of what can be done with and what can be seen through the peritoneoscope. He definitely stated that this instrument had very limited surgical use and did not supplant regular surgical procedures. However, the use of the peritoneoscope prevents unnecessary surgery in such cases as cancer where abdominal metastasis can be seen. A very interesting discussion, led by Dr. Thomas J. Summey, followed. The members of the Society appreciated Dr. Lee's address on this new topic. They all realize that the abdominal cavity can now be visualized to a large extent without having to resort to exploratory laparotomy.

The valuable papers and documents of the County Society which date back to its inception are to be stored in a metal box in the Moorestown Bank and Trust Company for safe keeping.

The following officers, who will assume their duties in May, were elected:

President—Paul R. Sparks.
President-elect—E. V. Davis.
Vice-President—R. W. Betts.
Treasurer—Wm. P. Mulford.
Reporter—T. B. Dickson.
Secretary—Howard C. Curtis.
Board of Censors—Dean LeFavor.
Delegates to State Society—Wm. Bray, H. C. Curtis, R. W. Betts, S. Emlen Stokes, Marcus Newcomb.
Alternates to State Society—Luis Viteri, Paul Sparks, D. LeFavor, A. Peacock, F. D. Fahrenbruch.
Nominating Committee State Society—Marcus Newcomb.
Alternate—S. Emlen Stokes.
Nominating Committee County Society—J. Howard Hornberger.

The Keep-Well-Baby Clinics in Beverly and Delanco are without a doctor. Any doctor who is interested in filling one or both of these positions should communicate with Dr. Rodman or Dr. Curtis.

At the request of Dr. Wm. Bray, who was absent due to the sudden death of his mother, Dr. Hornberger announced for the Public Relations Committee that on January 29, 1948, a public meeting in the Moorestown Community House would be held under the auspices of the County Cancer Committee. The speakers of the evening will be Dr. Paul Sparks who will speak on "The Role of the General Practitioner in Cancer Control" and Dr. Wm. Bray, whose topic will be "The Aims of the Cancer Committee".

Dr. Thomas J. Summey stated that the State Cancer Committee was very anxious to start a Tumor Clinic at the Zurbrugg Memorial Hospital in Riverside. Dr. Summey again extended an invitation to all the county physicians to visit and help in the Tumor Clinic at the Burlington County Hospital.

CAMDEN COUNTY

Harold K. Eynon, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was called to order at 9:00 p. m., on Tuesday, January 6, 1948. The president-elect, George B. German, M.D., presided in the absence of the president, J. S. Shipman, M.D.

Dr. Elwood S. Paisley, Haddon Heights, and Dr. Anthony J. Repici, Haddonfield, were accepted into the society.

The scientific program consisted of case reports given by members of the society as follows:

Dr. Lester R. Wilson reported on some conditions simulating acute appendicitis. He reported two interesting cases: 1. A case of sickle cell anemia in crisis operated upon for appendicitis. 2. A patient with diabetic acidosis simulating severe appendicitis.

Dr. William Halbeisen reported in detail on a patient with severe hyperthyroidism treated successfully by propyl thiouracil with appropriate remarks on the use of anti-thyroid drugs.

Dr. Harold K. Eynon reported a case of idiopathic thrombopenia with splenectomy, failure to respond to treatment and death.

Dr. Samuel Goldman reported two patients with unrecognized cephalopelvic disproportions with pertinent observations as to the recognition and treatment of this condition.

CUMBERLAND COUNTY

E. C. Greene, M.D., Reporter

The December meeting of the *Cumberland County Medical Society* was held in the ballroom of the Hotel Cumberland, on the ninth, with its president, Dr. Sidney L. Siegel presiding.

Drs. Jesse W. Carll, Arthur D. Sewall, Harold W. Hendrickson, Ralph S. Philips, Walter L. Sydoriak and Risley J. Madi were elected to membership. Dr. Robert C. Brown was elected to membership by transfer from the Pennsylvania State Society.

After the business session, Dr. Siegel introduced Dr. J. Howard Hornberger, president-elect of The Medical Society of New Jersey, who gave an informative talk concerning the administrative problems and accomplishments of the state society. He presented a brief outline of progress of the program of the Medical-Surgical Plan, the official stand taken on current medical legislation and efforts toward more effective public relations.

Dr. Charles Cunningham opened the scientific program by introducing Dr. Henry Royster, associate in surgery at the University of Pennsylvania, who spoke on *Thrombo-Embolic Disease.* His presentation of the subject was a concise study of the most modern concept of the prevention and treatment of the condition. Dr. Royster gave the advantages and contra-indications of heparin and dicumarol, the indications for the ligation of the superficial femoral and, for the purpose of illustration, presented the case history of a woman who developed a septic thrombo-phlebitis of the pelvis following a Cesarian section. She was treated by a ligation of the inferior vena cava with a very satisfactory recovery.

ESSEX COUNTY

Asher Yaguda, M.D., Reporter

The December meeting of the *Essex County Medical Society* was held on Thursday, December 18, 1947, combined with the stated meeting of the Academy of Medicine of Northern New Jersey.

DR. CLYMONT MACARTHUR, president of the Academy of Medicine of Northern New Jersey, briefly outlined the successful projects initiated by organized medicine in Essex County.

DR. HARROLD MURRAY, president of the Essex County Medical Society, then took over the meeting. The minutes of the Council meeting were read and approved. Dr. Murray introduced the speaker of the evening, DR. ARTHUR S. W. TOUROFF, attending surgeon at the Mt. Sinai Hospital, New York, who spoke on the "Newer Advances in the Treatment of Congenital Heart Disease". Dr. Touroff, in a well-organized and brilliant discussion, outlined the value of surgery in congenital heart disease. While in the past, pediatricians were apt to content themselves with a diagnosis of congenital heart disease, today this is not enough. The precise diagnosis of the type of congenital lesion is of extreme importance because certain types are amenable to surgery. Surgery in congenital heart disease is of fairly recent development. The first operation on a human being performed for the correction of a congenital heart defect was done in 1938. Since that time, this field of surgery has developed rapidly.

Three types of congenital heart disease have been subjected to surgery up to the present time. The first type of congenital lesion, and the one which is best known and in which there is the most experience, is patent ductus arteriosus. The prognosis of patent ductus arteriosus is not good so far as normal life expectancy is concerned. Therefore, these cases should be operated upon as soon as the diagnosis is made. In the hands of experienced surgeons, the mortality and morbidity is no greater than that in any surgical procedure. The surgery consists of tying off the duct between the aorta and the pulmonary artery and the cure is prompt and permanent. In 137 cases of this type of congenital defect operated upon by Dr. Touroff, there were only two deaths, and these occurred in the first four cases.

Tetralogy of Fallot was the second type of congenital defect to come under surgical treatment. Children with this defect are markedly cyanotic and the operation should only be performed in severe cases, where the child is getting progressively worse and is bedridden because of marked anoxia. The defect in tetralogy of Fallot consists of a pulmonary stenosis, transposition of the aorta, a high interventricular septal defect, and right ventricular hypertrophy. The operation is not intended to correct the abnormality but on the contrary creates an additional abnormality to correct the intense cyanosis, dyspnea and exercise intolerance. This is done by taking one of the branches of the aorta, such as the subclavian artery, and anastamosing it with a branch of the pulmonary artery so as to by-pass the stenotic pulmonary artery. The operation was devised by Blalock and Taussig and is known as the Blalock-Taussig operation.

The third and newest of the surgical procedures for correction of congenital defects is less than two years old and only about 50 cases have been reported up to now in the literature. Like the operation for patent ductus arteriosus, the operation for coarctation of the aorta is a truly corrective procedure and not a substitute as is the operation for Fallot's tetralogy. Coarctation of the aorta should be suspected in cases of hypertension in a child, in which the blood pressure in the lower extremities is low. The degree of coarctation varies from complete atresia to various grades of stenosis. When coarctation is complete, the condition is dangerous and the patients do not live long. In these cases, operation should be done as soon as possible because if the coarctation is allowed to go unoperated for any length of time atheromatous changes take place in the aorta and make surgery more difficult. The operation consists of an excision of the coarctation and an end to end anastomosis.

The meeting was well attended and numerous questions were asked by the members present. Dr. Touroff's paper was enthusiastically received.

GLOUCESTER COUNTY

L. K. Collins, M.D., Reporter

With DR. JOSEPH HUGHES presiding, the regular monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, December 18, 1947.

DR. NORMAN CHESNEY, plant physician at Socony-Vacuum Oil Co., was elected to full membership.

It was decided to cooperate with the State School Health authorities in their four point program for better school examinations and improved school health program in general. The society also lent its support to the United States Public Health Service in its proposed county wide survey of the relation of dental caries and the fluorine content of the drinking water. Last year's study in Glassboro, Pitman and Woodstown showed all three municipalities to have a high fluorine content in their water and less dental caries than would be expected.

The following resolution was adopted by the Gloucester County Medical Society on the death of DR. HENRY B. DIVERTY: "In his death we have lost a forceful leader, a wise counselor, a kindly man and a dear friend. The Society desires to express its great appreciation of these qualities and enter upon the minutes this testimony to the memory of one we can ill afford to lose. With his magnetic personality, his rare gift of humorous expression and his wisdom acquired through wide experience, he was a dominant figure among his fellows. It is known that he was influenced by a strong religious feeling and he brought to every decision a sense of fairness which made his counsel much sought. His active interest, and his regular attendance at the meetings of the Gloucester County Medical Society, will long be remembered."

The scientific program was devoted to a very interesting and instructive discussion of "Management of Ear Infections" by DR. ORAM R. KLINE, otologist and otolaryngologist of Cooper Hospital, Camden, N. J.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting on December 2, 1947, at the Jersey City Masonic Club. Dr. Driscoll presided.

Dr. Joseph F. Londrigan, chairman of the New Jersey Committee of the National Physicians Committee, took the floor for the purpose of urging the members of the Society to continue their support of this organization, laboring as it is against powerful groups that are employing every subterfuge to pressure Congress into passing a national compulsory health insurance law. Dr. Londrigan called attention to an article in *The Reader's Digest* for December, "Our Most Dangerous Lobby" by Forest A. Harness, chairman of the House subcommittee on Publicity and Propaganda in the Executive Departments (composed of Democrats and Republicans), which has voted to expose those government officials who are responsible for building up an artificial, federally stimulated public demand upon Congress for enactment of legislation for compulsory health insurance. The National Physicians Committee, Dr. Londrigan stated, is to be commended and given as much financial support as possible.

Elected to membership were Dr. Dante P. Crisonino of Jersey City; Dr. Samuel Penchansky of Bayonne, and Dr. Moses M. Rothberg of West New York.

The speaker of the evening was Dr. Louis Faugeres Bishop, Jr., assistant clinical professor of medicine, New York University Medical College and visiting physician at Bellevue Hospital, who chose as his subject: *Recent Advances in the Diagnosis and Treatment of Heart Disease.* His subject being broad in scope, Dr. Bishop circumscribed his presentation of *recent* advances in the field of cardiology to the period since the beginning of World War II. He described a number of important developments in methods of diagnosis—such as catheterization of the heart, valuable in congenital heart disease; angiocardiography, of practical value in differentiating cardiac lesions; and the use of the direct-writing electrocardiographic machine, where an immediate diagnosis is required.

Among the most dramatic advances in the treatment of heart disease, Dr. Bishop described some of the cardiac surgery that is being done and the results obtained therefrom—this method of treatment being confined at present, however, to but a small percentage of cardiac patients.

Drs. Cangemi, Grieco and Thomas White participated in a discussion from the floor. Discussion was closed by Dr. Bishop.

MIDDLESEX COUNTY

Carlyle Morris, M.D., Reporter

The annual dinner meeting of the *Middlesex County Medical Society* was held at the Roger Smith Hotel in New Brunswick on the evening of December 17, 1947, at 6:30 p. m., with Dr. F. S. Taber presiding.

On recommendation of the Committee on Medical Ethics, the following physicians were elected to regular membership: Dr. Edward Brezinski, Perth Amboy; Dr. Philip J. Kunderman, New Brunswick, Dr. Norman Rosenberg, Highland Park, and Dr. Irving Silber, New Brunswick. Dr George J. Urban, New Brunswick, was elected to a two-year period of associate membership. On transfer from Essex County Medical Society, Dr. Chester T. Brown, New Brunswick, was elected to regular membership.

Under new business, the following resolution was introduced and approved:

Whereas, there is a need for increased facilities for medical education in general in the United States and an urgent need in particular in the State of New Jersey; and

Whereas, the health and welfare of the citizenry of New Jersey require the undergraduate education of additional physicians; and

Whereas, a medical school in the State of New Jersey would have an effect of maintaining a higher standard of excellence of medical education and medical practice and provide additional hospital facilities in the State; and

Whereas, a medical school under the control of and having the prestige of an old and established university has proven the most successful in past experience in medical education:

Therefore Be It Resolved, that the members of the Middlessex County Medical Society being desirous of promoting the health and welfare of the citizenry of the State of New Jersey and of promoting the high standards of medical education and practice do hereby request the President and Board of Regents of Rutgers University of the State of New Jersey to establish a Class A medical school as an integral part of Rutgers University at the earliest practical time; and

Be It Further Resolved, that a committee be appointed by the President of the Middlesex County Medical Society to cooperate with the President of Rutgers or other interested parties for the establishment of this Class A medical school; and

Be It Further Resolved, that a copy of this resolution be presented to the President and to the Board of Regents of Rutgers University, and to the President, to the Board of Trustees and to the Committee on Post-Graduate Education of The Medical Society of New Jersey.

In the opinion of the members, this was one of the most important resolutions ever considered by the Society. It was fully discussed and it is hoped that other county societies in New Jersey will be stimulated to a like discussion in order that the question of establishing a medical school in New Jersey might be given the earnest consideration and support that is necessary and urgent.

On recommendation of the Committee on Nominations, the following officers were elected:

Dr. Edward F. Klein, Perth Amboy, *President.*
Dr. F. M. Clarke, New Brunswick, *Vice-President.*
Dr. Murray B. Jacobson, Perth Amboy, *Secretary.*
Dr. George J. Kohut, Perth Amboy, *Treasurer.*
Dr. A. J. Pellicane, New Brunswick, *Reporter.*

Important changes in the Constitution and By-Laws, as adopted at the November meeting, were the election of a Board of Trustees and the election of the members of the Committee on Medical Ethics

instead of appointment by the President of the Society as in the past. Both the Board of Trustees and the Committee on Medical Ethics are considered to be composed of able and energetic members of the Society and it is believed that the change will make for a more efficient county medical society in the future.

The newly elected officers were presented and assumed their respective offices.

DR. FREDERICK S. TABER delivered the customary dissertation of the retiring president. He reviewed the work of the society for the past year and thanked the committees for their conscientious and efficient work in the performance of their assigned tasks. He stated that he had enjoyed the past year very much and regretted that more of the things he had hoped to accomplish could not have been done. He urged further consideration of necessary changes in the code of medical ethics. The importance of regular attendance at the monthly meetings was stressed if the members of the profession were to be fully informed of the trends in the practice of medicine, and be stimulated by the newer knowledge in therapeutics.

The guest speaker of the evening was Marjorie Shearon, Ph.D., Washington, D. C. Dr. Shearon is well known as a former consultant to the United States Senate Committee on Labor and Public Welfare, and is now in charge of the Shearon Medical Legislative Service in Washington. The subject of her address was "Paradise Unlimited or the Menace of the Police State". She spoke both informatively and interestingly of the present trend in medical legislation and urged all physicians to become familiar with these trends if they would desire to influence proposed legislation vitally affecting the future of medicine in the United States. Socialized medicine in New Zealand and England was discussed. The Society was fortunate in securing Dr. Shearon as guest speaker and the members gave her a vote of thanks for her unusually informative talk on a subject so important at the present time.

In closing the meeting Dr. Klein asked for the cooperation of the members of the Society in the coming year, and pledged himself and the other officers to their best efforts in meeting the responsibilities of their offices.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The regular monthly meeting of the *Monmouth County Medical Society* was held earlier than originally scheduled because of the holidays, at the Monmouth Memorial Hospital, Long Branch. Dr. Samuel Edelstein, chairman of the program committee, introduced the speaker, DR. RALPH COLP, a surgeon at Mount Sinai Hospital in New York. Dr. Colp presented a paper on the *Present Status of the Surgical Treatment of Peptic Ulcer.*

The relative merits and limitations and complications of gastro-enterostomy, sublatal gastrectomy and vagotomy were discussed. Dr. Colp stated why he preferred the combination procedure in most cases of vagotomy and sublatal gastrectomy. The advantages and disadvantage of infradiaphragmatic vagotomy over the supradiaphragmatic approach were also discussed. "No gastric ulcer should ever be treated by vagotomy as all gastric ulcers should be investigated for malignancy as it is in these ulcers that malignant degeneration is apt to occur."

Regardless of treatment, some ulcers will recur and these gastro-jejunal ulcers are more resistant to treatment than the original ulcer. The gastrectomy and vagotomy procedure is probably superior because it removes both phases of hyperacidity. In closing, Dr. Colp stated that vagotomy has been a disappointing procedure.

The discussion that followed was initiated by DR. OTTO HOLTERS and DR. VICTOR KNAPP. Questions and comments were presented by other members of the society.

MR. JAMES E. BRYAN, Executive Officer of The Medical Society of New Jersey opened the business meeting with comments on public relations and the state program to improve these relations.

The establishment of a new category for membership was discussed. This will be "courtesy membership" for the benefit of men too young to be honorary members, who are residing in Monmouth County but practicing in another county or state. He will have all the privileges of membership, except the right to vote and hold office. He will not pay dues.

The following doctors were elected to full membership: DR. PAUL IBSEN of Bradley Beach, DR. BENJAMIN GOLDSTEIN of Asbury Park, and DR. OTTO LEHMANN of Long Branch.

Dues are to be sent to Mr. Vincent Gorman, Executive Secretary, at 506½ Burlington Avenue, Bradley Beach.

Dr. Brindle was appointed chairman of the committee for the annual outing. To serve with him are Dr. Quick, Dr. Feldman and Dr. Wilkins.

SUSSEX COUNTY

Katherine E. Stewart, M.D., Reporter

Under the chairmanship of DR. MARTIN I. KIRSCHNER, its president, the *Sussex County Medical Society* held its regular meeting at the Governor Haines Inn, Hamburg, on the evening of December 19, 1947.

During the business session approval was given for the setting up in the county of an x-ray unit, donated by the State Department of Health.

A committee appointed to cooperate with county chapter of the Red Cross on a central blood registry, reported that plans had been drawn up for the establishment of the registry.

The Society approved the formation of a county chapter of the Woman's Auxiliary, provided the physicians' wives are interested. The group is still of the opinion that there is no need for such an organization in this county.

DR. JACOB FIERSTEIN of Green Point Hospital, Brooklyn, N. Y., was introduced. His excellent presentation on *X-ray Diagnosis of Lesions of the Alimentary Tract* stimulated a lively discussion.

BOOK REVIEWS

Clinical Hematology. By Maxwell M. Wintrobe, M.D., Professor of Medicine, University of Utah. 2d ed., 862 pp.; illustrated with 197 engravings and 14 plates, 10 in color. Philadelphia, Lea & Febiger, 1946. $10.

The author traces the development of the blood elements from their formation to their eventual destruction clearly and concisely, so that the reader can grasp this difficult problem readily. Descriptions of the various blood dyscrasias are well written and complete. The sections into which each is divided show the results of careful study, so that each is complete in itself.

Newer concepts, elaborated since the appearance of the first edition, have been carefully weighed and analysed, and then placed in suitable positions in the book, so that they fall in easily wth the flow of the text.

The author has done well with his grouping of the many synonyms, with which hematology is becoming burdened. However, more emphasis could have been given to this subject. This is a problem that should be clarified in some manner before long. The confusing and often unnecessary array of names which describe mere variations of dyscrasia patterns ought to be consolidated.

The illustrations, as in the previous edition are excellent. Every chapter has been revised and many new items added. The description of the technical methods, which are unquestionably the back-bone of the proper study of hematology are well written.

The book is a great contribution to hematology and is an invaluable reference work as well as a textbook for all concerned. It is an asset to any book shelf.

MURRAY SHULMAN, M.D.

Practical Physiological Chemistry. By Philip B. Hawk, Ph.D., Pres., Food Research Laboratories, Inc., Long Island City, New York, Bernard L. Oser, Ph.D., Director, Food Research Laboratories, Inc., Long Island City, New York, and William H. Summerson, Ph.D., Associate Professor of Biochemistry, Cornell University Medical College, New York. Pp. 1323. 12th ed. Philadelphia and Toronto, Blakiston company, 1947. $10.

The present edition marks the 40th year that this well-known text has been available. Dr. Bernard L. Oser, who collaborated in the last edition, and Dr. William H. Summerson have joined Dr. Philip B. Hawks as major authors. The skyrocketting progress of physiologic chemistry in the decade since the last edition is reflected, in part, by an increase of 355 pages in the new edition. The index is larger and the appendix is more extensive.

New sections have been added on the polarograph, isotopes, sulfa drugs, the Warburg tissue-slice procedure, the theory and practice of photoelectric analysis, electrophoretic fractionation of the plasma proteins and composition of foods and vitamins. There is also material on new experiments, tests, methods and preparations.

An extensive new section devoted to photometry has been added. A method for sulfonamide determination is included.

The chapter on hormones reflects the strides achieved in the study of adrenal cortical hormones. Brief mention is made of the hormonal role of the kidney in hypertension.

Progress in the field of carbohydrates, fat and protein metabolism has resulted in revision and expansion of that chapter. The importance of phosphoric acid esters in the formation and breakdown of glycogen is given due emphasis. The "tricarboxylic acid cycle" of aerobic oxidation of carbohydrate is described.

As must be expected, the chapter on vitamins has been greatly enlarged. There is an adequate discussion of all the vitamins and the corresponding deficiency diseases. This includes five pages devoted to folic-acid. Descriptions of various new methods of vitamin determinations are included in this chapter.

To the present edition has been added a chapter on antibiotics and metabolic antagonists, which include penicillin, with a method of determination, and a short section on streptomycin.

This is a useful adjuvant to the library of all interested in medicine and allied sciences. It will be of great help to the clinician, the pathologist, and those associated with the academic aspects of medicine.

PHILIP SHULMAN, M.D.

Occupational Diseases of the Skin. By Louis Schwartz, M.D., Louis Tulipan, M.D., and Samuel M. Peck, B.S., M.D. 2nd edition. 146 illustrations. Philadelphia, Lea & Febiger, 1947. $12.50.

The second edition of this unique text comes at the end of a war resulting in development of new chemicals and processes.

In addition to expanded coverage (over 200 pages more than in the first edition) occupational hazards in forty more types of work have been included.

Interesting chapters on prevention, treatment, diagnosis and medico-legal aspects of occupational disease of the skin are new. These are skillfully handled so that the text is always simple and richly rewarding, for the student, practitioner and specialist.

The book is a new one thoroughly revised and re-edited. New recent references make each chapter an avenue for further exploration.

The paper is of good weight, glossy, the type clear and nearly all the photographs are sharp enough to be helpful.

This book should be useful to anyone faced with the perplexing problems of occupational skin diseases.

IRVING SHAPIRO, M.D.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Lodovico Mancusi-Ungaro, Newark

GANGWAY FOR ORGANIZATION

Despite subzero weather, reorganization of the now inactive counties is proceeding at a rapid pace. Letters are now being sent to the 450 physicians of Bergen County for members of their families eligible for Auxiliary membership. Hunterdon County Medical Society has appointed a physician-consultant for the school health program and for Auxiliary reorganization. Cumberland too has partly acquiesced by allowing us to communicate with the women of that county for membership at large. And rumor has it that Salem is also interested.

Can anyone help with Sussex, Morris and Somerset?

LEGISLATION

The Auxiliary to The Medical Society of New Jersey stands ready to assist the legislative committee of that Society in all of its efforts during this legislative session. The importance of this phase of Auxiliary work has been stressed at all levels, and each Auxiliary county president has been primed for action. Women all over the country are taking an interest in legislation, and too many heed the words of a few and simply follow the leader. Now is the time for intelligent thinking, independent voicing of opinion, and for courageous leadership to help the physicians in their fight against regimentation. The entire Auxiliary is ready to help where and when it can.

EXECUTIVE BOARD MEETING

Mrs. Thomas H. McGlade, Press and Publicity

Mrs. Lodovico Mancusi-Ungaro presided over the Executive Board Meeting of the Woman's Auxiliary to The Medical Society of New Jersey which was held on January 12, 1948, at 315 W. State Street, Trenton, N. J.

Reports of the standing committees and county presidents were read during the morning session. Miss Esther Dandois, president of the newly reorganized Cape May County Auxiliary was introduced and made welcome.

We were particularly fortunate in having Mrs. Bruce Schaefer, of Toccoa, Georgia, legislation chairman of the Woman's Auxiliary to The American Medical Association, address the group in the afternoon. She was introduced by Mrs. James H. Mason, program chairman. Mrs. Schaefer discussed the new health bills and urged that each Auxiliary member familiarize herself with them. Clear understanding of proposed medical legislation is vitally important to all of us.

A tentative Auxiliary Program for the Annual Meeting was presented by Mrs. David B. Allman.

Mrs. Frederick G. Wandall, chairman of the nominating committee, gave her suggested slate.

Laws pertaining to the school health program were explained by Mr. James E. Bryan, executive officer to The Medical Society of New Jersey.

Finally, delegates and alternates to the convention of the American Medical Association were nominated.

AUXILIARY REPORTS

Atlantic County
Mrs. Matthew Molitch
Chairman, Press and Publicity

The regular meeting of the *Woman's Auxiliary of the Atlantic County Medical Society* was held on December 12, 1947, at the Hotel Traymore with Mrs. Edward H. Dyer presiding.

Mrs. Irving Shavelson, Chairman of Ways and Means, announced that a Sweepstakes Dance will be held by the Auxiliary at the Hotel Traymore on

Saturday, April 10, 1948. The proceeds from this affair will go into the Nurses' Scholarship Fund, a project with a two-fold purpose: To supply a nurse, after her first six months' probationary training at the Atlantic City Hospital, with a regular monthly income until her graduation; and to give a cash award to a nurse, upon her graduation, to enable her to make advanced study in nursing.

Mrs. Dyer announced that the Medical Society would entertain the Auxiliary at a Buffet Supper Dance to be held at the Traymore on December 19, 1947, in gratitude for the past years when the ladies entertained the men at the annual Christmas party.

An invitation, too, has been issued by the Medical Society to the Auxiliary to attend the January meeting when the program will consist of a panel on the "Problems of Family Life". The Auxiliary promptly accepted the invitation. The public is also invited to attend.

Gifts were collected at the meeting for the children of the Betty Bacharach Home.

Camden County

Mrs. Wilmer F. Burns,
Chairman, Press and Publicity

The Annual Legislative Meeting of *The Woman's Auxiliary to the Camden County Medical Society* was held January 6, 1948, at the home of Mrs. Thomas McConaghy, Camden.

Mrs. Ralph K. Bush, Legislative Chairman, arranged a Legislative Quiz with Mrs. Lodovico Mancusi-Ungaro, state president, as moderator and four members forming a panel for discussion. The questions and answers were taken from the approved book *Check and Double Check* which later was distributed to the members who were urged to read it carefully and pass along the information to lay people. Our state president impressed upon the group the fact that we must work to prevent socialized medicine and help keep our American way of life.

Miss Jean Jalkiewiev rendered several vocal selections, accompanied by Mrs. Fred Homer.

During the business meeting it was unanimously voted to establish a scholarship fund of not less than $500 in either undergraduate or graduate field of nursing for girls in need of financial aid. The applicants will be chosen by the Nurse Committee comprising Mrs. Arthur J. Casselman, Chairman, Mrs. Karl S. Russell, Mrs. Harold D. Barnshaw, and Mrs. H. F. Westcott.

Mrs. Karl S. Russell, Public Relations Chairman, announced *Live and Like It,* a series of radio health broadcasts sponsored by the Medical Society, would be presented over WCAM every Friday from 11:00 p. m. until 11:15 p. m. for a period of twelve weeks. The series of broadcasts is a part of the Health Education Program.

After the program was completed Mrs. Gordon West and her committee served tea to the group.

Essex County

Mrs. Asher Yaguda,
Chairman, Press and Publicity

The regular meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held at the Academy on Monday, January 26, 1948, with Mrs. Daniel E. Kavanaugh presiding.

A report of the first meeting of the Essex County Council for Improvement of School Health Service was presented by Mrs. Albert B. Tucker, Chairman.

Mrs. Frank Forte gave a short summary of medical legislation to date.

Dr. Jerome G. Kaufman, Assistant Professor of Medicine at New York Medical College and Attending Physician at Newark Beth Israel Hospital, was one of the guests of the afternoon. Dr. Kaufman spoke on "The Importance of Heart Disease Today", a subject of great interest to all of us.

Reverend Dr. C. Marshall Muir, of the Munn Avenue Presbyterian Church, reviewed "The Bishop's Mantle" by Agnes Sligh Turnbull.

Hudson County

Mrs. Morris Bresev
Chairman, Press and Publicity

On December 1, 1947, following a short business meeting, *The Woman's Auxiliary to the Hudson County Medical Society,* held its annual Christmas Party at the Young Women's Christian Association Building, Jersey City. Mrs. William Gleeson, first vice-president, presided in the absence of the president, Mrs. Louis Perkel.

Mrs. Eleanor Reed Alter presented an informal talk on *Christmas in Many Lands.*

Christmas carols were sung by the Joseph F. Brandt Junior High School Glee Club of Hoboken. Miss Isabelle Sciorsci was in charge.

Refreshments were served and gifts were exchanged. Mrs. Richard Lempke, hostess for the occasion, was assisted by a large committee.

Union County

Mrs. Herschel S. Murphy,
Chairman, Press and Publicity

The Poinsetta Ball sponsored by the *Woman's Auxiliary to the Union County Medical Society* was held on January 17, 1948, at the Baltusrol Golf Club in Springfield, and was one of the most successful social events of the current season. Elaborate decorations featured the poinsetta theme. A popular orchestra played for dancing. Highlight of the evening was an exhibition of South American rumba, samba and conga steps by the Argentine dancers. Special gifts for audience participation in a rumba went to Mrs. William C. O'Brien of Elizabeth and to LeRoy LaClair of Westfield. Dr. Graham Newberry of Cranford was presented with a radio and Mrs. Roland Fisher of Plainfield received a fitted suitcase. Candid souvenir photographs of the guests were taken. The Auxiliary Student Nurses' Fund will benefit from the proceeds of the ball.

The affair was under the able leadership of Mrs. Bertram J. Sauerbrun of Elizabeth, general chairman; Mrs. William O. Wuester, president; Mrs. F. J. DeCesare, entertainment; Mrs. Edward Gonczy, finance; Mrs. Edward T. Lynch, Mrs. P. L. Hipple, Mrs. J. A. McGeary, decorations; Mrs. Max Ehrlich, tickets and publicity, and Mrs. E. O. MacDonald, refreshments.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **February, 1948** **No. 2**

CHEST X-ray surveys are now being carried on in many parts of the country or are being planned for the near future. The primary object of such surveys is to find cases of pulmonary tuberculosis while they are still in the early asymptomatic stage of the disease. However, it has been common experience everywhere that other intrathoracic lesions are discovered also by this procedure. In such cases the private physician must correlate the X-ray reports, the laboratory findings and the clinical picture in order to arrive at a diagnosis.

THE VALUE OF CHEST X-RAY SURVEY IN THE DIAGNOSIS OF CARDIOVASCULAR DISEASE

A chest X-ray survey may be of considerable value in the discovery of heart disease in addition to abnormal pulmonary conditions. There are various cardiac lesions which may cause changes in the contour of the cardiac silhouette or in the prominence of the great vessels. It is true that individuals with a serious heart disease such as arteriosclerosis of the coronary arteries may have entirely normal cardiac shadows in the X-ray film. Certain cardiac abnormalities which are detected by other forms of radiologic examination may not be apparent on the posterior-anterior view obtained in the routine chest film. Although it must be admitted that the X-ray survey cannot be 100 per cent effective in detecting individuals with cardiovascular disease, it may be a very useful device.

Enlargement of the left ventricle may be detected by the chest X-ray and may be due to any one of the following causes: hypertensive heart disease, arteriosclerotic heart disease, chronic rheumatic valvular heart disease with aortic stenosis and/or insufficiency, luetic aortic insufficiency and other less common cardiac lesions. Localized enlargement of the lower left cardiac border may be found in aneurysm of the left ventricle following coronary thrombosis with myocardial infarction. Right ventricular enlargement may be manifested by an increase of the heart shadow to the right of the midline. Commonly, however, moderate or even marked enlargement of the right ventricle may cause an increase in the heart shadow to the left. The posterior-anterior projection does not always, therefore, in itself give adequate information as to which chamber of the heart is enlarged.

An increased prominence of the pulmonary trunk and pulmonary artery shadow on the superior portion of the left heart border may be found in mitral stenosis, interauricular septal defect, patent ductus arteriosus, pulmonary arteriosclerosis, chronic cor pulmonale and thryrotoxicosis. It may also be present when the left side of the heart has decompensated as in hypertensive heart disease.

Relatively diffuse cardiac enlargement may occur in myxedema, thiamine deficiency, anemia and myocarditis. In myxedema, the cardiac contour may be globular.

Pericardial effusion may be manifested by cardiac enlargement to both right and left with fairly convex lower heart borders. Chronic constrictive pericarditis may be suggested by deposits of calcium seen in the cardiac shadow. Distention of the vena cavae may be caused by constrictive pericarditis and may be detected on the routine chest film.

Abnormalities in the thoracic aorta may be found in a survey. Arteriosclerotic or syphilitic aneurysm of the aorta may present a striking X-ray appearance. Lesser degrees of tortuosity and ectasia may commonly be seen in adults of

the older age groups. Deposits of calcium may be seen in the aortic knob. Decreased prominence or absence of the aortic knob may suggest coarctation of the aorta. This is especially true if scalloping of the rib margins and left ventricular enlargement are present. Abnormalities in the origin or course of the aortic arch may also be found.

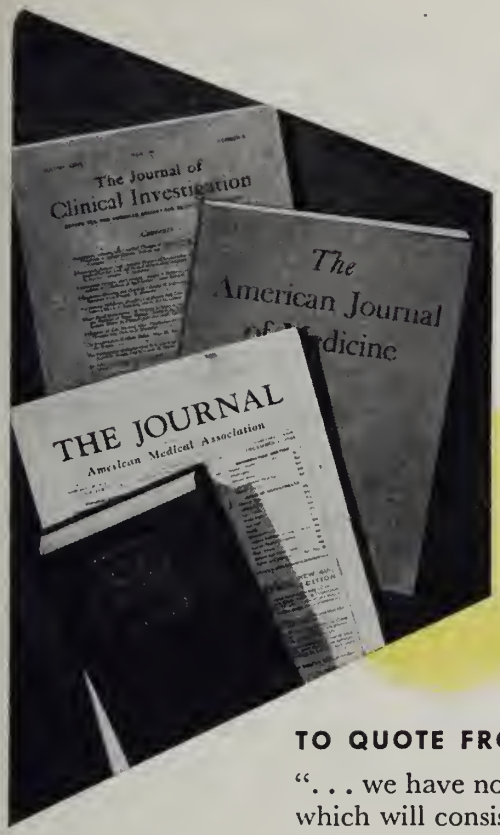
Congenital cardiac lesions may be detected also in a survey. The tetralogy of Fallot may be suggested by the combination of the peculiar boot-shaped heart plus the anemic appearing lungs. Interventricular septal defects may cause enlargement of both the left and the right ventricle. Dextrocardia will be evident by the striking X-ray appearance of the chest. Other congenital cardiac lesions have been mentioned above.

It is essential that those individuals whose routine X-ray films show cardiovascular abnormalities be referred to their physicians for further studies. Only by obtaining a careful history and physical examination and by making judicious use of the electrocardiogram, other forms of radiologic examinations, and other laboratory procedures can an exact diagnosis be arrived at and proper management instituted. It is possible that some completely curable cardiac lesions may be discovered by the survey. The health of other individuals with cardiac disease may be preserved by regulating activity to an optimum level and by applying appropriate therapeutic measures.

The value of a survey to the health of a community is impossible to estimate. It will depend in large measure on how well the physicians of the community perform the task of arriving at an exact diagnosis and advising appropriate therapy.

The Value of Chest X-ray Survey in the Diagnosis of Cardiovascular Disease, George N. Aagaard, M.D., The Journal-Lancet, June, 1947.

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1. *Combined Staff Clinics of the College of Physicians and Surgeons, Columbia University: Am. J. Med.* 1:675 (Dec.) 1946.

2. *Comroe, B. I.: J.A.M.A.* 128:848 (July 21) 1945.

3. *Council of Pharmacy and Chemistry: New and Nonofficial Remedies, 1947, Philadelphia, J. B. Lippincott Company, 1947, p. 477.*

4. *Freyberg, R. H.; Block, W. D., and Levy, S.: J. Clin. Investigation* 20:401 (July) 1941.

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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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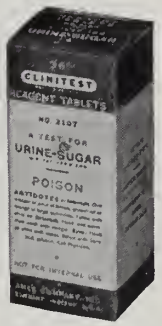
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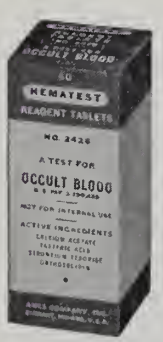
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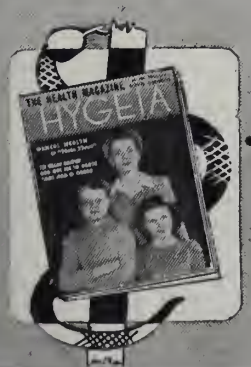
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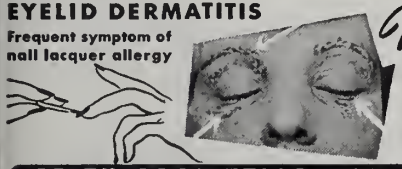
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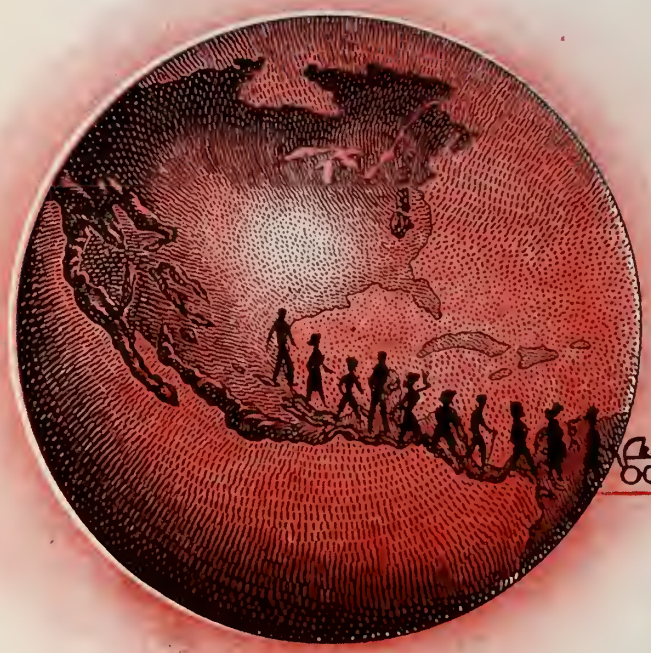
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°Spies, T. D., and Butt, H. R., in Duncan, G. G., Diseases of Metabolism, W. B. Saunders Co., Phila., 1942, p. 453.

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OF

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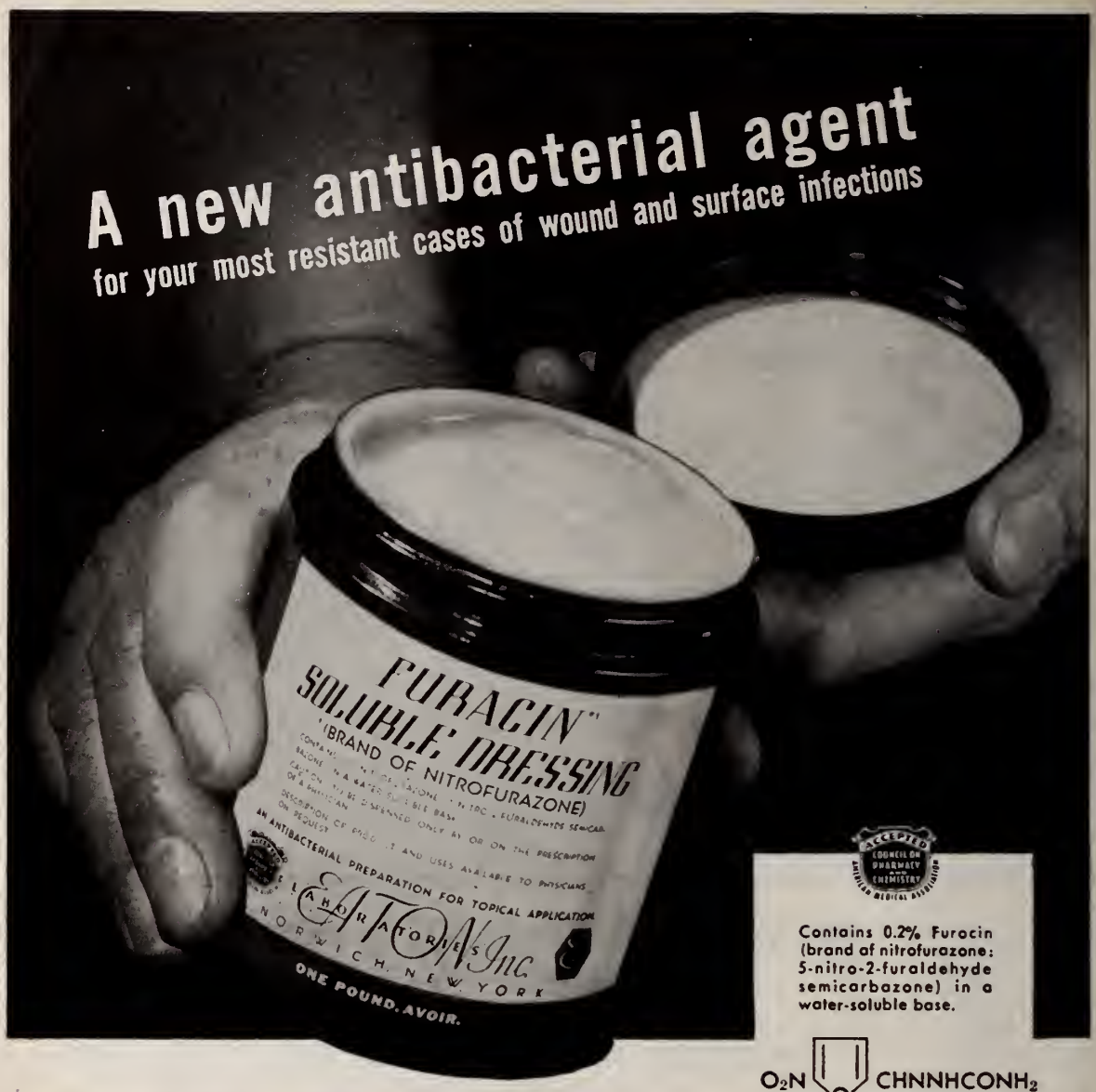
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*Snyder, M. L., Kiehn, C. L. & Christopherson, J. W., Mil. Surg. 97:380, 1945.

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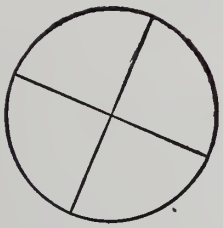
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[1]Harris, S. C.; Ivy, A. C., and Searle, L. M.: THE MECHANISM OF AMPHETAMINE-INDUCED LOSS OF WEIGHT: A Consideration of the Theory of Hunger and Appetite, J.A.M.A. 134:1468 (Aug. 23) 1947.

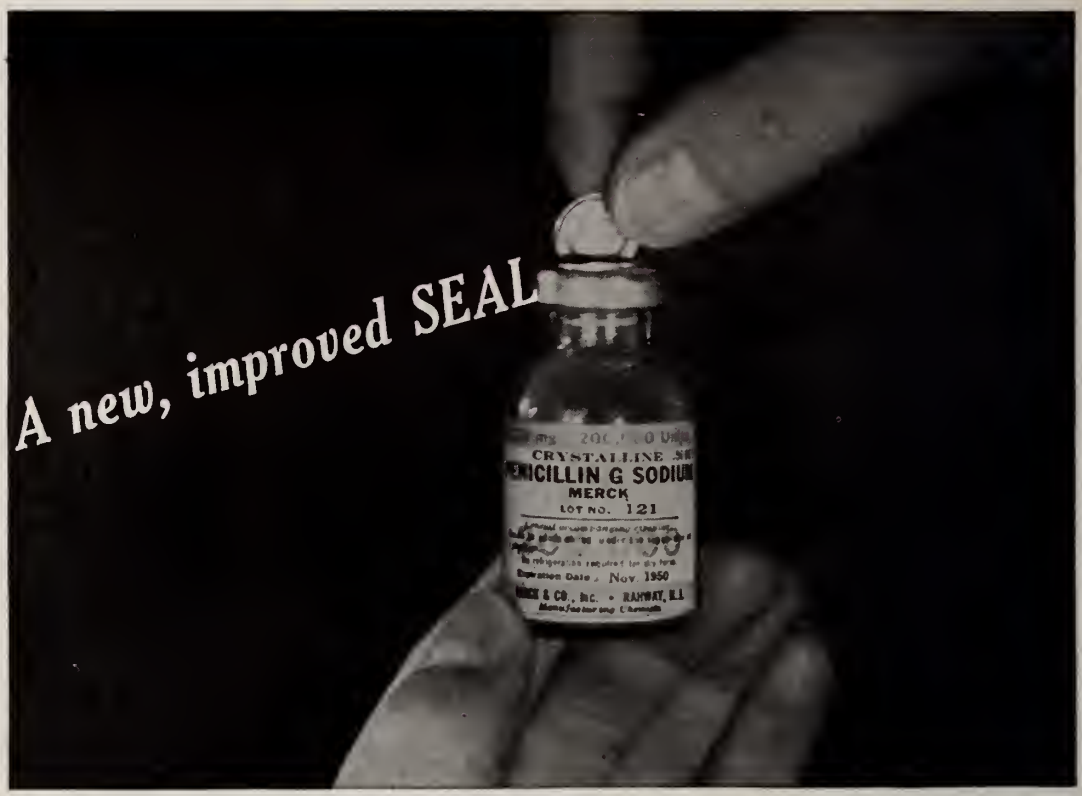
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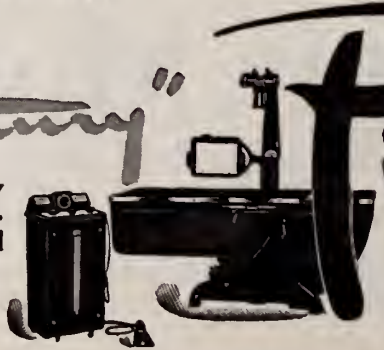


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1. Arbesman, C.E., et al., Jl. of Allergy 17:275, Sept. 1946
2. Feinberg, S.M., and Friedlaender, S., Am. Jl. Med. Sci. 213:58, Jan. 1947.
3. Fuchs, A.M., et al., Jl. of Allergy 18:385, Nov. 1947.

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1. Jones, B. B.: Virginia Med. Monthly, 74:241, June, 1947.
2. Levine, S. Z.: J. A. M. A., 128:283, May 26, 1945.
3. Schroeder, L. J. et al: J. Nutrition, 32:413, Oct., 1946.

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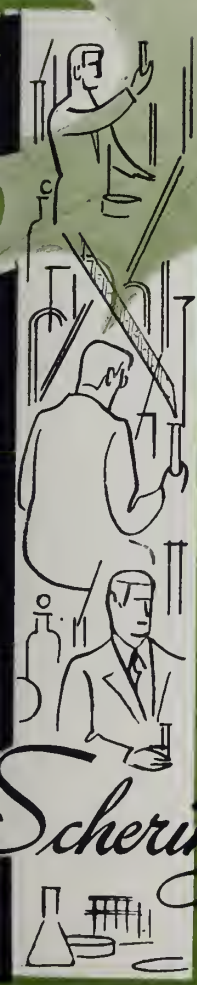
Cameron, A. T.: Recent Advances in Endocrinology, ed. 5, Philadelphia, The Blakiston Company, 1945, p. 1.

The ever-widening scope of hormone therapy is the outcome of decades of progress in laboratory research, clinical investigation and pharmaceutical manufacture.

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world's largest manufacturer of sex hormones has pioneered in noteworthy developments in this field.

Further advances in endocrine treatment foreshadowed by current scientific activity are inseparably related to the continuing initiation of effective, well-tolerated therapeutic agents.



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SPECIFY

Abbott Vitamin Products

"the baby needs vitamin D from the beginning"...



"*. . . and its administration should be started in the first two weeks after birth.*"[1]

To initiate and maintain optimum growth . . . to prevent rickets . . . *early* vitamin D administration is urged. The wholly natural vitamins A and D from time-proved cod liver oil itself are provided for infant "drop dosage" in White's Cod Liver Oil Concentrate Liquid. Average antirachitic protection for infants costs about a penny a day. Liquid—Tablet—Capsule forms.

1) Marriott, W. M. and Jeans, P. C.:
Infant Nutrition, St. Louis, The C. V. Mosby Co., 1941, p. 222.

White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.



"...especially during periods of rapid growth..."

". . . older children require prophylactic doses of Vitamin D"[1]
—it is during these periods that permanent dentition is developing and the drain on nutritive resources is heavy.

Youngsters and adolescents genuinely enjoy taking White's Cod Liver Oil Concentrate Tablets. Notably pleasant-tasting, the tablets provide natural vitamins A and D derived exclusively from cod liver oil itself, the standard by which all antirachitic agents are measured. Free from oily bulk and unneeded calories. Each tablet provides as much vitamin A and D as one teaspoonful of cod liver oil.* Also in Liquid and Capsule forms.

1) Kugelmass, I. N., Newer Nutrition in Pediatric Practice, p. 653, Lippincott, Phila., 1940.
*U.S.P. Minimum Standards

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Answer: The GUILD OPTICIAN, who is so often in contact with people in all walks of life and is able to refer the Eye Physician frequently and at the same time he suggests the best for his own patients.

next issue: WHY

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two-way cough therapy



expectorant plus spasmolytic action

MONOBEN

SYRUP

new relief for coughs due to colds

COMBINING expectorant and antispasmodic efficacy, Monoben Syrup affords prompt relief from the discomforts of persistent coughing. Harassing bronchial spasms are relieved by the spasmolytic action of Sodium Benzyl Succinate while efficient expectorant drugs allay irritation and act to liquefy tenacious mucus.

The two-way action of Monoben is free from unpleasant side-effects, for Sodium Benzyl Succinate exhibits marked freedom from cardiac and respiratory depression, nausea, and digestive disturbances. Monoben is indicated for both children and adults.

EACH TEASPOONFUL OF MONOBEN CONTAINS:

Sodium Benzyl Succinate	1 gr.
Potassium Guaiacolsulfonate	1 gr.
Chloroform	¼ min.
Tartar Emetic	1/100 gr.
Sodium Citrate	1¼ gr.

in a palatably flavored glycerin-syrup vehicle

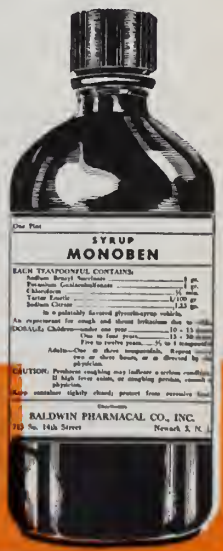
Monoben is stocked by leading New Jersey wholesalers and any pharmacist can fill your prescriptions.

DOSAGE

Children -	Under one year	10 - 15 drops
	One to four years	15 - 30 drops
	Five to twelve years	½ - 1 teaspoonful
Adults -	1-3 teaspoonfuls. Repeat every two or three hours as required.	

BALDWIN

WRITE FOR SAMPLE AND LITERATURE AND NOTE THE DELIGHTFUL FLAVOR-APPEAL.



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PHARMACAL COMPANY, INC.

713 So. 14th Street **Newark 3, N. J.**



DO YOU KNOW WHAT THESE SYMBOLS STAND FOR?

Rexall

DRUGS

You can depend on any drug product that bears the name Rexall.

Noah was in at the birth of this symbol. Since, in almost all lands, it has come to mean one thing: Hope. See a rainbow in the sky and you see a promise of days less laden with trouble.

The familiar Rexall sign is a modern symbol: Up and down the land, displayed proudly by about 10,000 independent and reliable drug stores, it signals an important message to the millions. Here is a symbol, it says, that assures the highest pharmacal skill in compounding your prescription. It means, further, that all drugs used are potent, pure and uniform . . . all laboratory tested under the rigid Rexall control system.

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PHARMACEUTICAL CHEMISTS FOR MORE THAN 45 YEARS

Experience is the Best Teacher



It's true in medicine—

John William Ballantyne

(1861-1923)

proved it in obstetrics

BALLANTYNE, in his early studies of anatomical and pathological conditions found in the new-born, sensed the value of routine prenatal care in obstetrics. As a pioneer for prenatal care he was the first to establish a clinic for the expectant mother. World-wide acceptance of Ballantyne's concepts quickly followed his successful experiences in prenatal supervision.

Experience is the best teacher in choosing a cigarette, too!



MORE PEOPLE ARE SMOKING CAMELS THAN EVER BEFORE!

Yes, experience *is* the best teacher in choosing a cigarette. Millions of smokers who have tried and compared different brands have found that Camels suit them best. As a result, more and more people are smoking Camels as the "choice of experience."

Try Camels. See if your own taste doesn't appreciate the rich, full flavor of Camels. See if your own throat doesn't welcome Camel's cool mildness.

Let your own experience tell you why more people are smoking Camels than ever before.

According to a Nationwide survey:

More Doctors Smoke CAMELS

than any other cigarette

When 113,597 doctors from coast to coast — in every field of medicine — were asked by three independent research organizations to name the cigarette they smoked, more doctors named Camel than any other brand!



No other crop could grow here



Vast areas of the country would have to be considered wasteland, so far as human nutrition is concerned, were it not for the ability of livestock to feed on the grasses and roughage growing in the many areas which do not lend themselves to cultivation.

Our livestock population turns many plants, in themselves inedible by man, into meat . . . man's preferred protein food.

Thus livestock makes land, which otherwise would be useless for human nutrition, produce an outstanding protein food for man. This is of added importance today because of the world-wide scarcity of high-quality protein foods.

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Pain RELIEF IN CHILDBIRTH



One of the Simplest, Safest and Most Satisfactory Methods

Careful consideration of all the methods advocated for the relief of pain during childbirth leads to the conclusion that local infiltration anesthesia combined with Demerol and scopolamine is one of the simplest, safest and most satisfactory methods for the average woman in the hands of the average practitioner.

For detailed discussion, see Alfred C. Beck: Obstetrical Practice. Baltimore, Williams and Wilkins Co., 4th ed., 1947, page 403.

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DEMEROL®
HYDROCHLORIDE
Profound Analgesia Usually Without Respiratory Depression
Warning: May be habit forming.
Narcotic blank required.

NOVOCAIN®
Dependable Local Anesthesia

DEMEROL and NOVOCAIN, trademarks reg. U. S. & Canada, brand of meperidine and procaine hydrochloride, respectively.

The businesses formerly conducted by Winthrop Chemical Company, Inc. and Frederick Stearns & Company are now owned by Winthrop-Stearns Inc.

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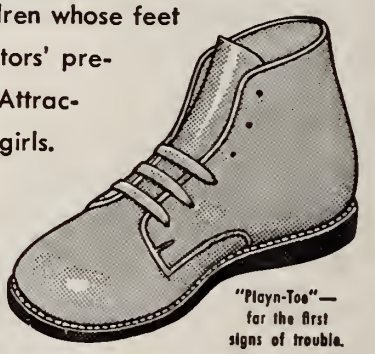
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- PRONATION (ANKLING IN)
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A complete line of famous Edwards CorecTred shoes for children whose feet need extra support. Doctors' prescriptions carefully filled. Attractive styles, for boys and girls.

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"Playn-Toe"— for the first signs of trouble.

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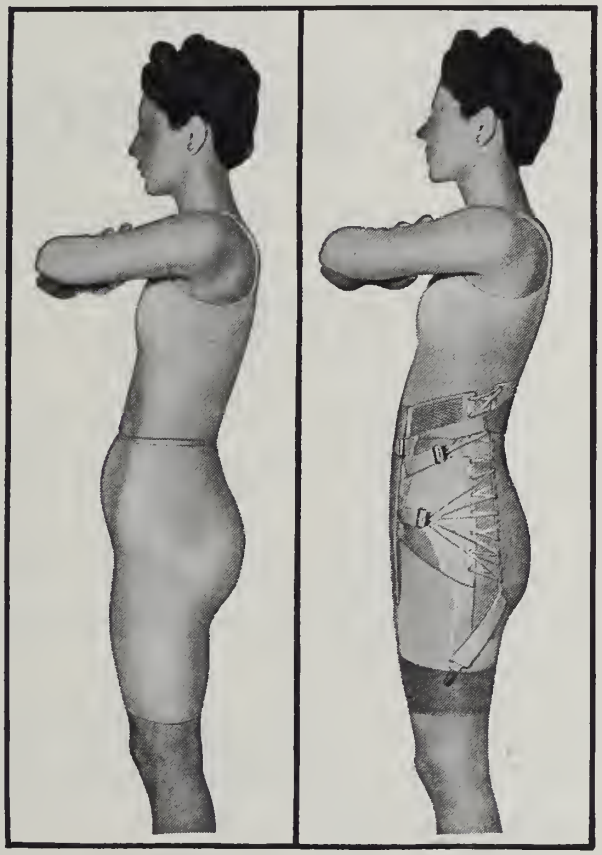
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Open Mon., Wed. and Fri. Evenings

Aid in conservative treatment when the fifth lumbar vertebra slips on the sacrum



Patient of intermediate type of build; roentgenograms showed spondylolisthesis, grade 1, with congenital defects. Symptoms developed after a fall on the ice during pregnancy.

Same patient after application of support. Patient reported relief from pain which was confined to the back and called attention to the ease and comfort in the wearing of the support.

. . . advantages of the CAMP lumbosacral support

. . . ***THE WELL BONED BACK***—Curves in and under the gluteal muscles, relieving the tension of these muscles on their attachments.

Wide shaped piece of material at top (fastening in front) holds the support still more closely about the lumbar spine.

. . . ***THE SLIDE LACING ADJUSTMENT***—Assists in steadying the pelvic girdle.

It also allows for reinforcing with aluminum steels or Camp Spinal Brace.

The elastic releases make for comfort.

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MODERN TESTED DIAPER SUPPLY

DIAPERS

FOR CUSTOMERS' *EXCLUSIVE* USE

Washed separately, dried separately, packed separately.

- The container furnished for used diapers while in the home sprinkles contents with an efficient antiseptic solution.
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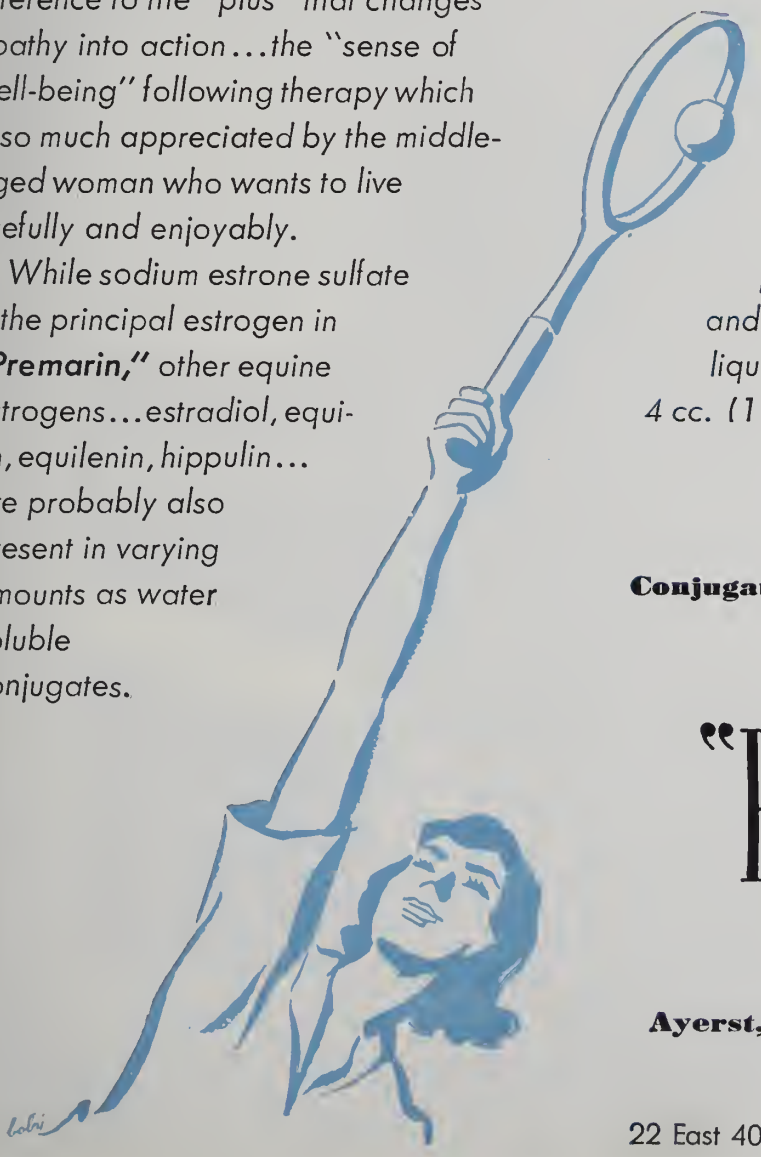
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middle age + verve

Verve or apathy in middle age? For the menopausal patient this is usually determined by the degree of relief from the distressing symptoms so often associated with declining ovarian function.

Gratifying and prompt remission of disturbing symptoms may be obtained with **"Premarin."** *Outstanding among comments made by patients receiving this naturally occurring, orally active estrogen, is the reference to the "plus" that changes apathy into action...the "sense of well-being" following therapy which is so much appreciated by the middle-aged woman who wants to live usefully and enjoyably.*

While sodium estrone sulfate is the principal estrogen in **"Premarin,"** *other equine estrogens...estradiol, equilin, equilenin, hippulin... are probably also present in varying amounts as water soluble conjugates.*



Three potencies of **"Premarin"** *enable the physician to fit the dosage to the individual needs of the patient: 2.5 mg., 1.25 mg. and 0.625 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).*

Conjugated Estrogens (equine)

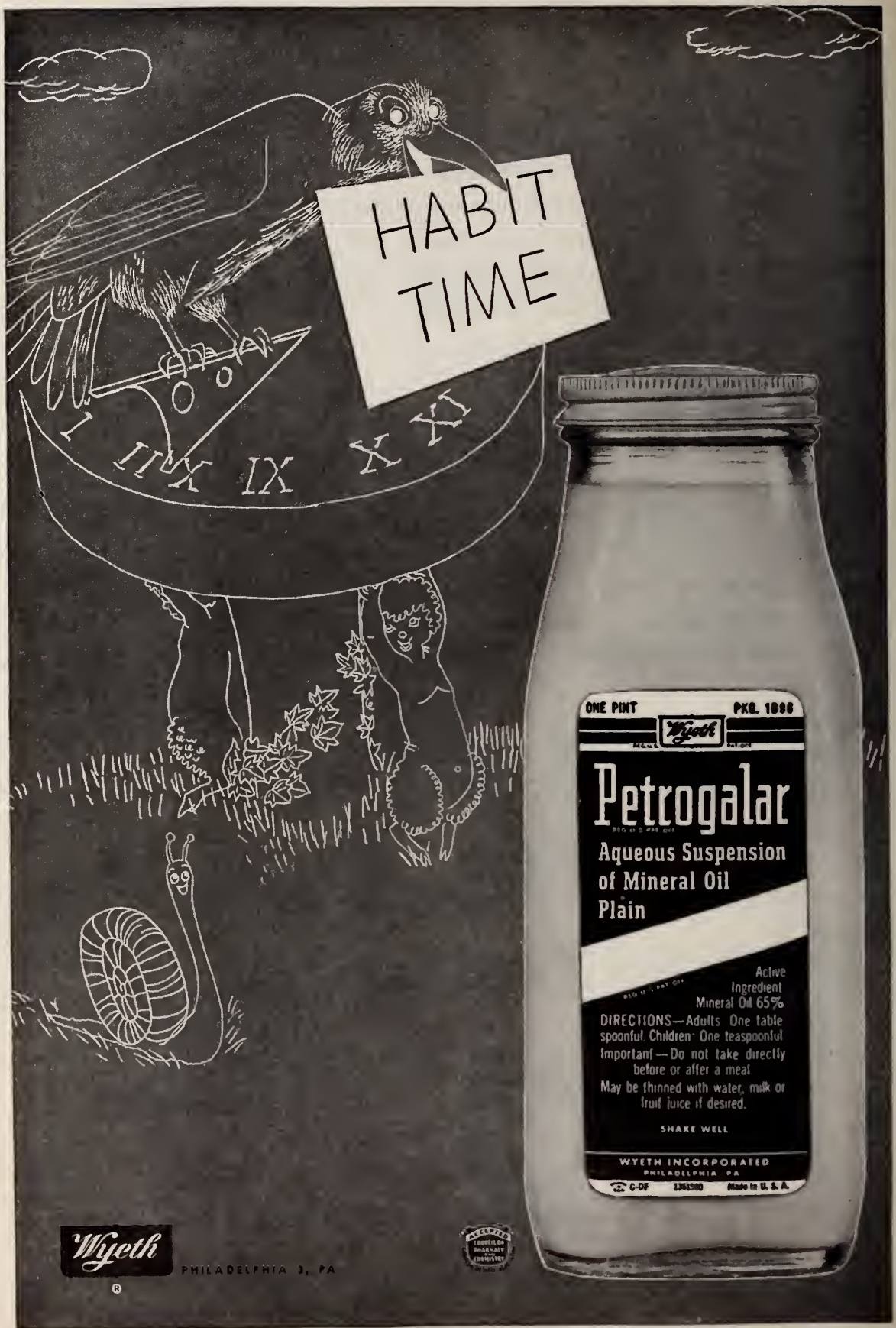
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Ayerst

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ONE PINT
PKG. 1898
Wyeth
Petrogalar
Aqueous Suspension
of Mineral Oil
Plain
Active
Ingredient
Mineral Oil 65%
DIRECTIONS—Adults One table
spoonful. Children One teaspoonful
Important—Do not take directly
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May be thinned with water, milk or
fruit juice if desired.
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Reaching more than 23 million people . . .

This Parke-Davis "See Your Doctor" message will appear in LIFE and other national magazines.

A reproduction in full color will be sent on request.
Write Parke, Davis & Company, Detroit 32, Michigan.

Some things you should know about operations

No. 210 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



OF ALL THE RECENT ADVANCES in medical science none have been more dramatic than those in surgery and the fields related to it. Take appendicitis, for instance.

Not very many years ago, having your appendix out might have meant a fairly long and uncomfortable hospital sojourn, followed by several tedious weeks of getting back your strength. And with it all you might have had good reason to fear such complications as peritonitis or pneumonia.

Nowadays, except for a few rare cases, the removal of an appendix is not considered a serious operation. And many operations which were considered of major seriousness as recently as 1930 are now often relatively simple.

Because of notable advances in training and surgical skill, many of the risks have been almost eliminated. Complications following operations are far less common. And most patients recover in a shorter time, and with less discomfort than formerly.

Such progress in surgery has been hastened by significant developments in four important fields.

1. Anesthesia. The administration of anesthetics has become a specialized science. New anesthetics have been developed—less toxic, less upsetting to respiration and heart action. With modern anesthesia the patient has a far easier time when undergoing surgery. Post-operative nausea and vomiting, which were previously almost taken for granted, are now much less frequent.

2. Infection-fighting drugs. Peritonitis, once feared as a frequent complication of abdominal surgery, today is uncommon. The use of such agents as the sulfa drugs and penicillin—to treat infection or to guard against it—has almost eliminated many of the infections which formerly constituted the greatest dangers in surgical procedures.

3. Early ambulation. Doctors have found that getting patients out of bed soon after operations not only speeds recovery, but also prevents many of the discomforts formerly suffered. Bowel and urinary functions are quickly restored. Gas pains are usually avoided. It is not unusual nowadays for a patient to be well enough to go home from the hospital in less than ten days after a major operation.

4. Body Nutrition. One of the problems in surgery has been that the condition which makes an operation necessary is usually one which has depleted the patient's nutritional reserves, and therefore lessens his ability to recover promptly from the operation itself.

In recent years, however, medical science has broadened its knowledge of body nutrition.

Today, it is possible to determine in what a patient's body is deficient—whether he needs whole blood, vitamins, salts, carbohydrates, protein.

Each of these elements can be replaced—making it far easier for the patient to go through an operation. Post-operatively, also, recovery is hastened by supplying the body's needs in easily assimilated form.

SEE YOUR DOCTOR. Give him your complete confidence at all times. If he advises an operation, follow his recommendation promptly. With modern surgery, with modern hospital care, you have little reason to be afraid.

Remember, too, that when surgery is indicated, a delay may be dangerous. Prompt action is likely to give you a quicker recovery—and an easier one!

Makers of medicines prescribed by physicians

PARKE, DAVIS & CO.

Research and Manufacturing Laboratories, Detroit 32, Mich.

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We Share with You the Care of Your Patient



The SARATOGA SPA

Here at the Spa, the care of your patient conforms to a medical guidance which you, yourself, have initiated.

Capable physicians are available in Saratoga Springs for consultation with your patient on the details of the program.

Surrounded by modern facilities for his treatment, your patient receives the benefit of your continuing medical direction in the care of circulatory and rheumatic disorders of a chronic nature.

In peace and quiet, a sick person achieves the mental and physical relaxation that gives full scope to the restorative powers of the Spa's famed waters.

"PHYSICIAN, GIVE HEED TO THINE OWN HEALTH"

Many physicians have come to the Spa for the same kind of treatments that have helped their patients here. After a restorative "cure" at the Spa, you, too, will return to your practice refreshed—revitalized—ready for the busy days that lie ahead.

For professional publications of the Spa, and physician's sample carton of bottled waters, with their analyses, write W. S. McClellan, M. D., Medical Director, Saratoga Spa, 159 *Saratoga Springs, New York.*

Listed by the Committee on American Health Resorts of the American Medical Association

THE EMPIRE STATE'S CONTRIBUTION TO THE MEDICAL PROFESSION

in the patient's hands

—0.05% SOLUTION



in your hands

—0.1% SOLUTION

PRIVINE

PRIVINE hydrochloride, 0.05 per cent, is sufficiently potent to produce long-lasting relief in the average case of nasal congestion in patients of all ages. It is therefore the Privine preparation of choice for regular prescription purposes.

Privine hydrochloride, 0.1 per cent, fills the need for an agent which will produce the intense vasoconstriction frequently necessary for adequate visualization and for pre- and post-operative shrinkage. It is therefore the Privine preparation of choice for direct use in the office or hospital.

When properly administered, Privine hydrochloride induces prolonged vasoconstriction with relative freedom from local or general side effects. Three drops will usually produce nasal decongestion lasting 3–6 hours. Overdosage should be avoided.

Issued: 0.05%, bottles of 1 fl. oz. and 16 fl. ozs. • Jelly, 0.05%, tubes of 20 Gm.
0.1%, bottles of 16 fl. ozs. only

Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

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PRIVINE (brand of naphazoline) • *Trade-mark Reg. U. S. Pat. Off.*



First breath, first bath, first bottle

In a life filled with "firsts", baby has no time to cope with such gastro-intestinal problems as carbohydrate fermentation and attendant distention and diarrhea—particularly during his first few weeks.

'Dexin' has proven an excellent "first carbohydrate" because 1) its high dextrin content is not fermentable by the organisms usually present in the intestinal tract, and 2) because it promotes the formation of soft, flocculent, easily digested curds.

Simply prepared in hot or cold milk, 'Dexin' brand High Dextrin Carbohydrate is easily adapted to increasing formula needs from month to month, and later, being palatable but not too sweet, is a welcome supplement to other bland foods. 'Dexin' *does* make a difference.

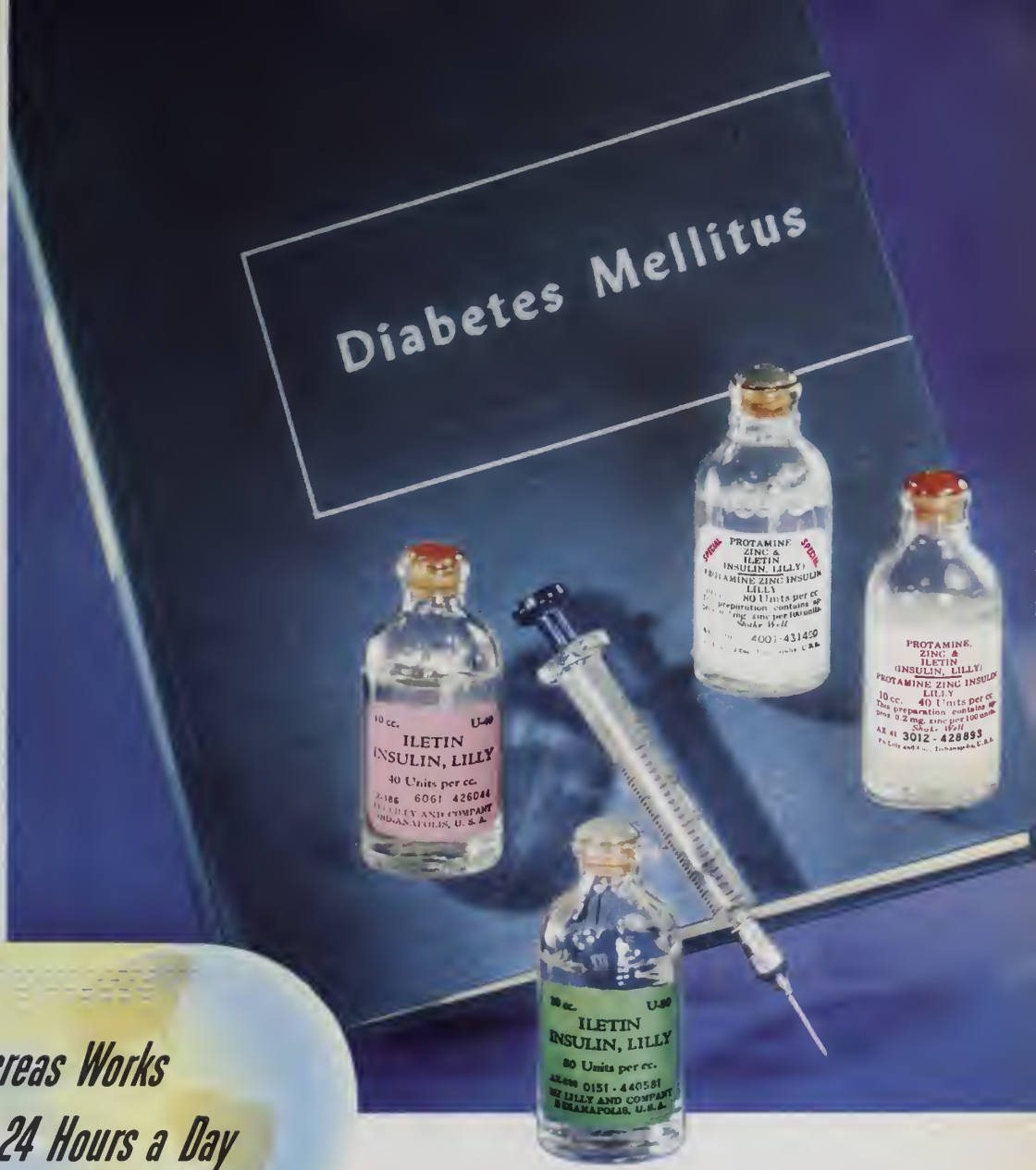
'Dexin' HIGH DEXTRIN CARBOHYDRATE
BRAND

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.

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The Pancreas Works 24 Hours a Day

THERE is no rest for a healthy pancreas. Endogenous insulin is supplied whenever required, day or night. So must it be with Insulin therapy in the diabetic. Adequate control means twenty-four-hour control—as nearly like nature's as can be devised.

Protamine Zinc Insulin has been found adequate in approximately two-thirds of the cases above the age of fifty-five and in nearly one-half of all age groups of diabetic patients who require Insulin treatment. Suitable combinations of Insulin with Protamine Zinc Insulin will provide satisfactory control in the balance of the cases.

Preparations of Iletin (Insulin, Lilly) and Protamine, Zinc & Iletin (Insulin, Lilly) are available in concentrations containing 40 and 80 units per cc.

Lilly

ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U. S. A.



Lilly in China

THE WORLD has been immeasurably enriched by the literary legacy of Chinese scholars, ancient and modern. Chinese medicine has also made important contributions, among which are the drugs Ma Huang and kaolin.

Since 1918 Eli Lilly and Company has been represented in China. In 1928 the Shanghai Branch was established. Through the years the scope of Lilly activity in China gradually increased. As might be expected, from 1941 to 1946 a sharp curtailment was unavoidable. The increasing emphasis on science and industry in this area will inevitably bring with it important scientific advances. Lilly contacts with men of research in China assure the physicians in America and elsewhere of a share in the best of Chinese medical thought.

LILLY INTERNATIONAL

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

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THE PRESIDENT'S PAGE

THE MEDICAL SOCIETY AND VOLUNTARY HEALTH AGENCIES

The working relationship that has been built up in recent years between The Medical Society of New Jersey and most of the voluntary health agencies in our community has brought untold benefits to the people.

Popular interest in the public health movement has resulted in the present great proliferation of health agencies with total annual national budgets approximating $50,000,000 in 1944. Originally this was met with mistrust and apprehension on the part of the medical profession in many places. In fact, in some parts of the country even today there is little cordiality and less cooperation between organized medicine and the voluntary health agencies in the community.

It must be granted that even though here and there individual physicians, and occasionally medical societies, took a leading part in founding and developing these agencies, nevertheless in some other areas they were created, without benefit of medical advice or assistance, to meet needs which the medical profession has ignored or refused to recognize.

The evolution of an active sense of partnership between organized medicine and voluntary health agencies is not many years old and far from universal even yet.

The technic of cooperation founded upon mutual understanding and the recognition of a community of purpose has perhaps gone further in New Jersey than nearly anywhere else in the country.

In our state, the isolation of medicine from other community forces working in the field of health is a thing of the dim and distant past. Conversely, the fear of the medical profession, the mistrust or the misunderstanding of our motives,

and the unwillingness to accept our guidance in medical affairs—conditions still to be found in some other states—likewise seem to have been long-since forgotten by our friends in the public health movement.

We and they have found that the talents and assets each of us brings to the improvement of community health exactly complement those brought by the other. Generally speaking, the peculiar contribution of medicine is its professional competence—the soundness of its technical advice, the authenticity of its sponsorship. The special contributions of the lay agency, on the other hand, include its financial resources, its technical means and experience in presenting a case to the lay public, and its facilities for developing lay leadership that can arouse public enthusiasm for its cause.

When these two distinctive contributions are united, they can accomplish great things. And they are doing so in New Jersey. Most of the state-wide lay health organizations, such as the New Jersey Division of the American Cancer Society, the New Jersey Tuberculosis League, the New Jersey Chapter of the National Foundation for Infantile Paralysis, and others, have accepted the advisory committees of The Medical Society of New Jersey in their respective fields as their own advisory committees to guide them in the investment of the funds they have available for health or medical purposes. In this way an effective partnership has been set up between those who have the technical knowledge as to what should be done and those who have the machinery and technic of doing it—for the enhancement of public health and welfare.

Our friends in the public health movement in New Jersey have come to realize that The Medical Society of New Jersey can be depended upon to take a progressive and sympathetic attitude toward any proposition that promises to improve health services or medical care for the people. Consequently, our advice is readily sought and generally listened to with considerable respect. The organizational set-up which has embodied this working partnership is gradually being extended with minor modifications in each case to cover all the established voluntary organizations for health education and service. The formula for cooperation is well developed and the spirit is there to implement it.

Royal A. Schaaf, M.D.
President.

ORGANIZED MEDICINE AND ORGANIZED LABOR

Fifteen million Americans belong to labor organizations. With their families, they constitute a pool of 45,000,000 citizens—nearly all of them employed at skilled jobs, or dependents of workers so employed. They represent an enormous reservoir of friends—or critics. For most doctors these hard working Americans, accustomed to paying their own way in life, are the backbone of practice. One would expect that an intimate rapport would exist between this huge segment of the American citizenry and the medical profession which serves them. Truth is, however, that on a formal basis at least, there is scant contact between organized medicine and organized labor.

It is strange that there should be so meagre a working relationship between the two groups. After all, both are steeped in the tradition of the guild—pride in craftsmanship, a desire to maintain high standards of skill, and a sense of service to the public. And the average practitioner, let it be remembered, is a working man. Except on a tiny

scale, he is not an employer, and in only rare instances could he be classed as a "capitalist".

Labor's complaint about medical care has been well articulated. Labor says that under the conditions of modern medical science, health care is too expensive. The average workingman wants to be able to purchase medical care from his own resources. He has no more inherent desire to see medicine nationalized than he has to see his own labor union placed under federal regulation. If he looks with favor on plans for federalizing medical care, it is only because he has found that bills for physicians, hospitals, nurses and medications are taking too big a bite out of his own modest budget.

This is a challenge to organized medicine—a challenge that is *not* met by branding as "communist" or "alien", any protest against the high cost of medical care. There are, we believe, two better answers. First, plans can be formulated for making health services available at a cost within the reach of the average skilled worker. Second, it should be possible to show the workingman that cheap, mass medicine, delivered under compulsory regulation, by physicians working under sweat-shop conditions, is not—and can never be—good medical care. Indeed, the latter contention is one which organized labor should be able to grasp without difficulty, since it so closely parallels their own battle cry.

The problem of ameliorating relations between labor and medicine thus falls into two divisions. First, the creation and popularizing of a plan to lower the individual cost of medical care; and second, a mechanism for informing labor of the full implications of compulsory national sickness insurance.

The rising tide of voluntary health insurance, perfected by practical trial and error experimentation with various plans, suggests the answer to the first need. The insurance principle, which has proved so successful in reducing individual cost and risk in other catastrophies, can be extended to protection against the cost of sickness. In spite of this, organized labor still seems to show marked interest in the Wagner-Murray-Dingell Bill and similar types of legislation. This is easy to understand. There *are* some things to be said in favor of compulsory health insurance; those things are obvious and have been said very often and very loudly. There are also many defects—some, we believe, fatal—in such a program. The defects are more subtle, and little effort has been made to show organized labor this side of the picture.

Here then is the immediate need with reference to our relations with organized labor. We need a platform from which to speak to them. Such a common ground is furnished, for this state at least, by the young, vigorous, and growing New Jersey Health Congress. It is a forum where we can meet with the leaders of labor and discuss all sides of the problem without drama or demagoguery. It offers us a chance to present our case so that it gets a fair hearing. That is all we need and all we ask.

COME TO ATLANTIC CITY

This year's Annual Meeting has been scheduled for the week of April 26—just the right time of the year to enjoy Atlantic City at its best. The bill of fare offers an unusual mixture of entertainment, education and camaraderie. Progress in medicine will be landmarked by a number of new technical and educational exhibits. The scientific sessions promise to refresh the mind and the Chamber of Commerce assures us that the sunlight and breezes will refresh the body. Provision will also be made for refreshing the spirit. A preliminary program will be found beginning on page 119 of this issue, and the detailed schedule will be published in full in the April JOURNAL.

ORIGINAL ARTICLES

OSTEOID-OSTEOMA*

RAPHAEL R. GOLDENBERG, M.D.,† Paterson, New Jersey

In the twelve years which have elapsed since Jaffe[1] first described the clinical and pathologic characteristics of the benign tumor which he designated osteoid-osteoma, one hundred and forty-one cases have been reported. The youngest patient was fourteen months of age, and the oldest fifty-one years. The lesion is about twice as common in the male as in the female.

An osteoid-osteoma is usually about a centimeter in diameter and may occur in either cortical or cancellous bone. The tumor has been found in almost all bones, but is more common in the lower extremities. As yet it has not been reported in the clavicle. Although the cause is unknown, it is of interest to note that in three of the four cases to be reported there was a definite history of trauma.

SIGNS AND SYMPTOMS

Pain, the most constant symptom, is localized to the site of the lesion. On occasion, when the region of the lesser trochanter of the femur is involved, the pain may radiate to the knee. The pain is usually mild and intermittent at the time of the onset, and may be aggravated by activity. Later the pain becomes constant, increases in intensity, and is not relieved by rest in bed. Tenderness to pressure is constant, and is sharply localized to the site of the lesion. Swelling of soft tissues may be present in lesions of the short bones in the foot or hand as seen in Case 3. Atrophy, limitation of motion, and limp may be noted if the tumor has been present for some time and is situated near a point in the lower extremity, as in Cases 1, 2 and 4.

X-RAY

The roentgenographic appearance of an osteoid-osteoma depends upon the stage of the lesion. In early cases, the x-ray discloses a small oval area of rarefaction surrounded by a zone of sclerosis. The sclerosis varies in size from a narrow ring in cancellous lesions to an extensive zone of sclerosis which may extend for several inches on either side of the central focus in cortical shaft lesions. In the late stages the sclerosis dominates the roentgenogram, though this nidus may be demonstrated only by special roentgenographic technics.

LABORATORY FINDINGS

The histologic picture is characteristic and consists of vascular connective tissue with many osteoblasts and occasional osteoclasts surrounding osteoid tissue in varying stages of ossification. The lesion is usually sharply demarcated from the sclerotic bone. Routine laboratory tests of the blood, urine and bacteriologic cultures have been negative.

TREATMENT

Three of the four cases to be presented were treated surgically, and in each instance the symptoms disappeared. Because of the small size of the lesion it is imperative, that when necessary, roentgenograms are available in the operating room for accurate localization of the lesion, and for the post-operative assurance that the tumor has been completely excised. The removal of all or a part of the sclerosed bone does not appear to be necessary so long as the nidus has been removed.

CASE ONE

A white male, aged 29, was admitted on March 20, 1941, complaining of severe pain in the right hip region. The pain began ten months prior to hospitalization and gradually increased in severity. Six months after the onset of symptoms he began to limp. The

* Read at the Annual Meeting of the New Jersey Orthopedic Society, Newark, New Jersey, October 11, 1947.
† St. Joseph Hospital, Paterson.

1. Jaffe, H. L.: Archives of Surgery, 31:709 (August 1935). Also see the paper by Jaffe and Lichtenstein, Journal of Bone and Joint Surgery, 22:645 (July 1940); and the following articles: Horwitz, T.: Radiology, 39:226 (1942); Kleinberg, S.: American Journal of Surgery, 66:401 (1944), and the review of the literature by R. W. Lewis, American Journal of Roentgenology, 52:70 (1944).

pain became constant and radiated to the medial aspect of the right knee. There was no relief of pain on bed rest. He walked with a slight limp. There was three-eighths of an inch atrophy of the right thigh. Motions of the right hip joint were restricted in abduction and internal rotation. Tenderness was constant and localized to the region of the right femoral lesser trochanter. Roentgenograms (Fig. 1-A) revealed an oval area of rarefaction in the region of the lesser trochanter with sclerosis of the medial femoral cortex. At operation the lesion was localized by roentgenographic control. The patient was last examined in June, 1947, and there has been no recurrence of pain.



Fig. 1-A. Case 1. Roentgenogram, ten months after onset of symptoms shows oval rarefied area inferior portion of femoral neck proximal to lesser trochanter, with sclerosis of the medial cortex.

A window of cortical bone was removed. and a brownish colored lesion the size of a large pea, gritty in consistency was excised.

The report of the microscopic examination (Fig. 1-B X35) showed "the pea-sized bit of gritty tissue to be composed of sheets of osteoid which in places, particularly at the periphery, is undergoing vascularization and ossification. The focus is separated from the surrounding bone by a narrow zone of vascularizing marrow tissue. The cortical bone surrounding the focus is thick from periosteal new bone. Nowhere does one see any evidence of inflammation."

CASE TWO

A white male aged twenty was admitted on June 26, 1946, complaining of pain in the right calf since October, 1944, when he was kicked while playing football. The pain became constant and interfered with sleep. He walked with a slight limp. There was localized tenderness over the posterior aspect of the right tibia at the junction of the proximal and the middle thirds. Roentgenograms disclosed marked cortical thickening and sclerosis of the tibia. There was slight narrowing of the medullary canal. The oblique roentgenograms (Fig. 2) revealed the rarefied oval nidus. At operation the lesion was localized by roentgenographic control. The periosteum was thickened over the area and could not be elevated. A lima bean sized red-yellow area of densely packed cancellous bone was excised.



Fig. 1-B. Case 1. Section (X35) showing nidus.

The report of the microscopic examination revealed "narrow spaces containing fatty mar-

row. Some of the narrow spaces show dilated blood vessels. There is no cartilage and no inflammatory reaction."

The patient was last seen in August, 1947, and has been completely free from symptoms.

CASE THREE

A woman, aged 24, was admitted on February 19, 1947, complaining of pain in the left



Fig. 2. Case 2. Right oblique roentgenogram showing nidus within thickened cortex.

hand following an injury in September, 1946. The pain was constant, and worse at night. There was swelling of the dorsum of the left hand. The patient was unable completely to extend the third metacarpo-phalangeal joint. Tenderness was sharply localized to the ulnar aspect of the neck of the third left metacarpal bone. Roentgenograms showed marked cortical thickening of the third metacarpal bone with a small area of rarefaction in the neck of the bone. At operation the periosteum was adherent. A block resection was performed. The nidus was found in cancellous bone, and was removed. Roentgenograms (Fig. 3) were made of the nidus immediately after operation. The patient was relieved of pain.

The report of the microscopic examination revealed "spicules of normal bone separated by fatty marrow. However, there is

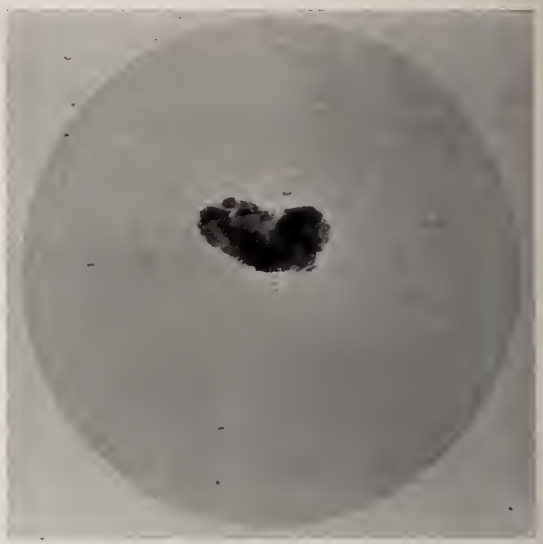


Fig. 3. Case 3. Roentgenogram of excised tissue.



Fig. 4. Case 4. Roentgenogram, fourteen months after onset of symptoms, showing the nidus in the inferior portion of the neck of the right femur, proximal to the lesser trochanter.

a circumscribed area in which there is both bone destruction and new bone formation. The marrow spaces contained fibroblasts, many thin-walled blood vessels and a few scattered lymphocytes and eosinophilis."

The patient was last examined in September, 1947 and has been free from pain.

CASE FOUR

A woman of thirty was first examined on April 15, 1946, because of pain in the right hip. The patient dates the onset of pain to March 17, 1936, when she was thrown to the floor and kicked in the right hip region. The pain has been present since the injury and gradually increased in severity. Roentgenograms (Fig. 4) made on May 8, 1937 (fourteen months after the injury) revealed an area of rarefaction situated just proximal to the lesser trochanter in the cortex on the inferior margin of the neck of the right femur. She was treated by diathermy, vaccine injections, immobilization in a plaster of paris hip spica and x-ray therapy without relief of pain. About two years after the onset of symptoms the pain radiated to the right knee region. Pain in the right hip and right knee joints has persisted to date. The pain was not relieved by rest in bed.

She walked with a limp on the right side. There was three-quarters of an inch atrophy of the right thigh and one-half inch atrophy of the right calf. Motions of the right hip were painful and limited in abduction and internal rotation. There was tenderness over the region of the right lesser trochanter. Roentgenograms made on April 6, 1946, (ten years after the onset of the symptoms) showed that the osteoid-osteoma persisted. Surgical excision was postponed until after the birth of her baby.

This case, although incomplete, is of particular interest because of the duration of symptoms.

SUMMARY

The four cases were presented to re-emphasize the clinical, roentgenographic and microscopic characteristics of osteoid-osteoma. Three of the cases were treated surgically with complete relief of pain. The fourth case was of interest because the symptoms persisted for ten years. A history of trauma was elicited in three of the four cases.

588 East 27th Street

PENICILLIN HELPS ANTHRAX

Penicillin has come to the aid of workers whose jobs bring them into contact with animal hides or infected animal products. According to a report in a recent *J. A. M. A.*, the drug has been found effective in anthrax. The authors are Ellingson, Kadull, Howe and Bookwalter.

The anthrax bacillus is transmitted to man through contact with diseased animals or infected animal products. Anthrax is characterized by a gangrenous carbuncle-like lesion surrounded by swelling and an abnormal accumulation of water in the tissues. The disease is always serious.

Reporting on 25 cases, the authors say that in several patients the infection occurred at sites of previous wounds. One lesion appeared at the site of a cigaret burn, two developed at sites of abrasions on the fingers and one occurred in a hangnail. Among the remaining 20 patients several had had ordinary pimples at the sites where anthrax lesions later appeared.

First evidence of infection is the appearance of a small red spot on the skin accompanied by intense itching. The spot grows within a few hours into a sac containing fluid. This sac may rupture early, leaving a small ulcer, or may enlarge by development of a ring of such sacs. Within two to six days after onset, the sac ruptures and begins to dry and the swelling recedes. In drying, a tough black crust is formed which is characteristic of this infection. This can usually be removed easily in 10 to 14 days after onset but is sometimes firmly embedded and may persist for long periods, finally leaving a punched-out ulcer which slowly fills with new skin tissue.

Treatment was begun as soon as diagnosis was made. All patients were treated with penicillin in total dosages from 1,000,000 units to over 4,000,000 units. The authors find it significant that in 22 of these cases the anthrax bacilli disappeared from the lesion in 24 hours or less.

Although the lesions passed through the different stages of the disease after treatment, all patients recovered uneventfully. The authors believe that "penicillin may have modified the course of these infections and that this therapeutic agent deserves further clinical trial in the treatment of cutaneous anthrax."

DEPRESSION MASKING ORGANIC DISEASES AND ORGANIC DISEASES MASKING DEPRESSION *

SAMUEL A. SANDLER, M.D., Hackensack, New Jersey

The experience of just living today has become difficult for all of us; doubly so for unstable individuals. The current housing shortage with its over-crowded homes lights up in many instances repressed aggressions and hostilities. The excitement of wars and rumors of war, tends to accentuate emotional instabilities. These things combined with our increased diagnostic skill and alertness have brought about a situation where the medical profession is seeing more depressions than at any previous time.

The mechanism of a depression is rooted in the attempt of the individual to introject a former beloved object and subsequently unconsciously destroy him by attempting to destroy oneself. The markedly depressed individual is concerned only with his narcissistic suffering and his unconscious hostility and aggressions. He is unconcerned with objective matters or with the presence of existing physical or organic disease. He is too involved in the loss of his "love object" to be much concerned about either his environment or the state of his physical well being.

CASE ONE

A violin teacher, 59 years old, was referred on May 8, 1947, with a complaint that for four years he was drowsy and had a feeling of experiencing a new situation as if he had been through this before. There was an associated and intermittent feeling of nausea and vomiting. He had refused to see a physician during these years because of a reactive depression resulting from the death of his devoted wife some six years before. In April, 1947, he fell down and injured his left shoulder and left chest with the result that he was "dragged" to the family physician by his son.

Neurologic examination revealed (1) impairment of gait on the left, (2) indistinctness of the nasal margins of the discs bilaterally, (3) left facial weakness, (4) left homonymous hemianopsia, (5) hypesthesia on the entire left side, (6) left inconstant suggestive Babinski, (7) hyperactive reflexes on the left, (8) weakness of the left upper extremity with a positive Strauss sign. A diagnosis of a right temporoparietal lobe tumor was made. X-ray of the skull disclosed "a focal lesion, most probably a tumor in the right parietal region extending towards the right frontal area". At operation, such a tumor was found.

In this case we have a sensitive individual who had definite symptoms of an intracranial lesion for four years. Yet he refused to see a physician. It was only when he injured himself that his family could force him to see a doctor. When the patient was asked why he neglected these serious complaints for four years, he stated that following his wife's death in 1939 he lost interest in everything, became melancholy and cared nothing about his physical condition or social status. Although he had been constantly urged to see a physician, he refused to do so as nothing seemed to matter any more. The world and all it contained became a matter of indifference to him. What had to be done was done as a routine without any feeling. Here the depression masked a serious organic disease—brain tumor.

CASE TWO

A housewife, aged 44, stated that for eight weeks she had felt completely exhausted following the nursing of her sick child. Her own chief complaint was insomnia. "I have no strength, I can't sit, can't lie, and I can't relax". She felt depressed for a long time because of her husband's excessive drinking. He would come home drunk and humiliate her in the presence of her daughter. After such experiences she had no desire to live but denied any suicidal attempts.

On examination, I found a mass about the size of a plum in the right breast and one about the size of a walnut in the other. The mass on the right was stony hard and immobile. The nipple on the right was retracted and seemed united with the substance of the breast. Diagnosis was cancer.

As a result of electro-shock therapy and x-ray radiation the patient gained ten pounds. Mentally she made an excellent recovery and when last seen was well adjusted. The surgeon thinks that with the removal of her breast the prognosis is good.

In this case we have a patient who had a malignancy in both breasts. It had been present for months, but she never complained to the family physician nor to me. There was absolutely no reference at all to any disease of the breast. It was only by an accidental find-

* Read by invitation before the New Jersey Neuropsychiatric Association, October 15, 1947.

ing during the routine examination preparatory to shock therapy, that this was discovered.

This patient was suffering from a mild reactive depression because of the physical and mental abuse engendered by her husband's cruelty to her.

CASE THREE

This is a 54 year old housewife whose depression had begun about a year before with feelings of "everything being lost". She had lost twenty pounds. Her hands kept swelling and she was unable to sleep. She had had twelve electro-shock treatments. She believed her husband was unfaithful, but what precipitated the final "blow-up" was the sudden enlistment of a favorite daughter into the Women's Army Corps. At the same time, another daughter was divorcing her husband. These things produced spells of crying and she had a feeling that everything and everyone she cared about was ruined.

The patient was treated by psychotherapy for two months with excellent results. By chance I became aware of an immovable nodule in her breast. Her family physician did a biopsy and the laboratory reported carcinoma.

In this case the only reason that this cancer was found in time was because the patient seemingly had improved to the degree in which she became interested in her physical well being and therefore was able to articulate her physical discomfort. Had this patient not improved this lesion would have become a progressive one with fatal consequences to the patient.

CASE FOUR

A 64 year old widowed female complained that she seldom had over two hours sleep a night, and felt incapable of doing any work because of "utter depression". Her husband had left her penniless and she was taken into the home of a married daughter. Shortly thereafter her son-in-law ordered her out of his home. She felt that she had been "betrayed" by her husband, by her daughter and by her son-in-law. The patient was panicky concerning her future and felt unwanted. She certainly had no economic or emotional security. Her physical illnesses were manifested by hypertension, cardiac disease and glaucoma. These seemed quite unimportant to her. What mattered were her feelings of depression, panic, betrayal and anxiety.

CASE FIVE

This 49 year old housewife gave the following complaints: "For the past two months I am always moaning. I don't sleep and I don't let anyone else sleep. I think I am insane. When my children come to see me I don't want to see them. I am up all night moaning and moaning and have made my mother sick. I am not interested in my home anymore. I feel I am going to die. We used to be such a happy family." Past medical history revealed a mental depression four years ago.

Examination disclosed a systolic murmur at the apex. The family was advised that because of the cardiac condition, electro-shock treatment would be a dangerous procedure. The relatives, however, insisted on it. I administered three "petit mal" treatments with good results.

MASKED DEPRESSION

I now present the converse picture, that is, organic disease masking a depression. The literature on this problem is meagre. In this type of case, the ego is more in touch with reality than in the previous group. The individual still has pride and a desire for self-esteem so that he covers up his real feelings of frustration, discouragement and disillusionment.

CASE SIX

A 66 year old executive reported that for three weeks he had noted difficulty in writing with his right hand and suffered an awkwardness and impairment of skill for fine movements when using the fingers of that hand. One of his duties was to sign the payroll and it became annoying to him, since he was no longer able to write his signature. He was seriously considering resigning from his top flight position as he felt that he was no longer able to carry out his duties. He had had an injury to the right elbow two years previously and a year later another injury with the resulting excess of synovial fluid about the right elbow joint. On a number of occasions he had pain and tenderness in that area.

He showed considerable anxiety regarding his ability to use his right hand. Blood pressure was 150/100. I found: (1) right facial asymmetry, (2) cardiac arrhythmia, (3) no evidence of motor weakness in any of the extremities, (4) inconstant sensory findings involving the fourth and fifth fingers of the right hand in the ulnar distribution for pain sensation, (5) atrophy in the right hypothenar eminence, (6) the DeJournal sign (which is found in ulnar nerve disease). Findings were suggestive of an ulnar nerve condition caused by a previous injury to the elbow involving the right ulnar nerve. Paralysis of the ulnar nerve may come on a long time after fractures, dislocations or injuries at the elbow from excessive callus or fibrous adhesions.

On further questioning I learned that he had an ankylosis of the distal and proximal interphalangeal joints of the thumb of the right hand since boyhood. The important story here was that his son, a college graduate, was placed in his office as an assistant but because of domestic difficulties had become a chronic alcoholic disrupting office routine and neglecting his work to such a degree that the patient, (in order to maintain discipline in his department) had to discharge him. This was a tremendous blow to the patient's ego as well as to his paternal feelings. This experience resulted in his feeling crushed and humiliated.

With the use of intensive psychotherapy and the help of physiotherapy, he made a good recovery. He was given insight and was able to carry on his duties satisfactorily.

CASE SEVEN

A woman of 54 complained of numbness and tingling of the left side of the face. For the past week she had had a twitching in the left eyelid. About four days previous to my examination she developed a severe pain in the right eye and down the left leg, left face and left arm. This was associated with impairment of gait on the left. She also suffered from anorexia. Her mother had died with cardiac disease associated with hypertension and the patient had had hypertension for years.

Neurologic examination revealed: (1) impairment of gait, (2) left homonymous hemianopsia, (3) sensory changes of functional midline character, (4) reflexes were equal on both sides, (5) no motor weakness or pathologic reflexes were found.

Although there was definite evidence of cerebral vascular lesion, the predominant situation was the feeling of depression. It developed that the symptoms which brought her to the physician began on the anniversary of her husband's death. This caused her to feel lonely, lost and panicky. In this case on the surface the picture apparently, as in the previous case, seemed to be organic; but the real disabling functional factor was her depression.

CASE EIGHT

This is a 43 year old roofer, whose present complaints began two weeks previously. He felt nervous and tense. His hands were tremulous, the right more than the left. He complained of shaking of the right shoulder. At mealtimes, his right hand became so tremulous that he could not drink liquids without spilling them. He pointed out that on May 27, while working on a roof he stepped on a gutter which gave way and he fell twenty feet, landing on his back. He was unconscious for a while and sustained fracture of the right transverse process of the third and fourth lumbar vertebrae. He had not returned to work since, because he was fearful about going up ladders. His chief anxiety seemed to be that he might never again be able to work as a roofer because of fear of high places.

Actually he had no complaints referrable to his lumbar spine injury. The tremors were functional. His wife and daughter had left him eighteen years ago and the daughter had refused to visit him even while he was in the hospital. During the entire separation from his wife he never became interested in any other woman. He lived in a rooming house by himself and had been lonely and unhappy during all this time because of separation from a wife and child for whom he still had considerable affection.

This man, who was an experienced roofer, stepped on a gutter, which he knew to be unsafe, with a resulting twenty foot fall which in my opinion was an unconscious attempt to commit suicide. Although this man had been hospitalized with an injured back (as manifested by two fractures of the lumbar spine only two months previously) there was not a single word of complaint in reference to this injury to the spine. This opens up the whole problem of unconscious drives and brings to the surface the many problems in workmen's compensation cases in which some workmen are continually being injured because unconscious conflicts manifest themselves in accident proneness.

When I gave this patient insight into the cause of his functional condition, he reacted with definite agreement and acceptance to the motion that his emotional conflicts were the real cause of his difficulty. He gasped as though a great load had been lifted from his chest.

CONCLUSIONS

I have presented eight cases in which there was a combination of organic and functional manifestations. Although the organic conditions were more or less serious, the functional situation (manifested by depression) seemed to be more direct and of greater practical consideration. Some patients with catastrophic organic illnesses ignore their conditions because the blow to their ego is so overwhelming that nothing matters and the wish to die is predominant. In other cases, where the ego is still adequate, the feelings of pride and false modesty mask the fact that their organic condition has become overemphasized. These organic symptoms are really secondary and act as a "smoke screen" for the feelings of frustration and failure within the patient's ego. What seems of greatest importance is the necessity, indeed the duty of every physician to keep reminding himself that although "functional", neurotic or mental disease may be present and obvious yet he must never forget that he is also a doctor who should constantly be on the lookout for organic disease. He must bear in mind that, in addition to the obvious, he must also be sure that he diligently searches for any evidence of organic disease. Any case may present surprises if the patient is thoroughly examined. This is true even when the "functional" disease seems overwhelming.

282 State Street

THROMBOPHLEBITIS MIGRANS IN CARCINOMA OF THE STOMACH

Lewis F. Baum, M.D., Otto S. Baum, M.D., John H. Hermann, M.D.,
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The existence of multiple venous thromboses in association with carcinoma is well known. One of the earliest descriptions of this coincidental association was that of Trousseau.[1] Since then a large literature on the subject has been summarized by Sproul,[2] who also analyzed 598 cases of carcinoma among which there was an associated thrombosis in 145 cases. Twenty of these showed multiple thromboses. Sixteen of the latter occurred with carcinoma of the pancreas, especially the body and tail, two of the stomach, and two of the bronchus. In the two cases of bronchogenic carcinoma, the multiple thromboses were due to direct invasion of the veins by metastatic cells, leaving the pancreas and stomach as the only organs whose carcinomatous degeneration was associated with multiple thromboses not caused by direct invasion. Migrating thrombophlebitis unassociated with carcinoma is known to occur also as a complication in leukemia, pernicious anemia, polycythemia vera, chronic infectious and debilitating diseases, but it occurs rarely so that statistically carcinoma stands in the foreground as the underlying disease.

Single or multiple venous thrombosis in the vicinity of a carcinomatous organ with invasion into the veins is well understood, but the etiology of multiple venous thromboses in veins distant from the carcinoma remains obscure. Because of its frequent association with carcinoma of the pancreas, Sproul states that "pancreatic tumor cells may exercise a general effect by discharge of enzymes into the circulation or by alteration of some process of digestion in the duodenum. It is also possible that their effect is entirely a local one wherever metastatic pancreatic cells chance to be in the blood stream. Coagulation of blood at those points due to secretory activity of a few tumor cells could initiate the process of thrombosis. Secretions examined, however, have failed to show evidence of metastases to the involved distant veins, and furthermore, the association of thromboses with carcinoma of the stomach can not be similarly explained, except that some digestive factor is implicated, possibly the better absorption of Vitamin K."

In view of the relative rarity of reported cases of carcinoma of the stomach with a presenting syndrome of thrombophlebitis migrans, we feel justified in adding another case to the literature.

CASE REPORT

A 41 year old clerk, was admitted to St. Mary's Hospital, (Orange, N. J.) on February 14, 1947, with pain in the back, fever, and weight loss of four weeks duration. He was well until July 1946, when he complained of vague abdominal discomfort unrelated to meals which disappeared after four weeks. A gastrointestinal x-ray series is said to have been negative at that time. In December 1946 he complained of pain in the rectum, consulted a proctologist who found an anal hematoma which was decapped and evacuated. He bled for a week after which he was again asymptomatic until six weeks before admission when he developed pain in the region of the right shoulder and the coccyx which slowly improved. Temperature at this time ran between 100 and 101, but the patient continued to work although he felt weak and had noted a weight loss of 45 pounds over a short period of time. Three weeks before admission he noted an alternating swelling of the ankles which lasted one week at which time he was forced to bed because of pain and swelling in the left thigh which subsided but left a "hard cord" running down his leg. A week before admission he began to have severe pain in the region of the left posterior lower ribs, aggravated by motion but not by breathing. At the same time he noted the development of a "cord" in his right arm similar to the one on his left leg.

On examination, he appeared acutely and chronically ill, and was in severe pain. Skin and mucous membranes were pale. There was an odor of old blood on the breath. Temperature was 102, pulse was 100. Examination of the head, eyes, nose and throat revealed no abnormalities. He had a soft systolic apical murmur, and a harsh precordial systolic murmur. The abdomen was soft and non-tender. No masses or organ edges were felt. There was tenderness to percussion over the 11th and 12th ribs posteriorly on the left. Genitalia were normal. Rectal examination revealed no masses or tenderness. The prostate

1. Trousseau, A.: Clin. med. de l'Hotel-Dieu de Paris, 3:80 and 739, 1877.

2. Sproul, E. E.: American Journal of Cancer, 34:566-585, December 1938.

was not enlarged. Superficial and deep reflexes were equal and active. The extremities showed the left saphenous vein to be thrombosed in its entire superficial course. The right median basilic vein was thrombosed and slightly tender. Peripheral pulses were patent.

Blood Count: Hemoglobin 9 gm (53%); RBC 3,220,000; Color Index 0.8; WBC 9,050; Polys 88%; Lymph. 4%, Mono. 6%, Eosin. 2%.

Platelet Count: 260,000.

Red Cell Fragility: Normal.

Blood Urea Nitrogen: 17 mgm/100.

Blood Culture: Sterile.

Stool: Positive for occult blood.

Chest x-ray indicated normal heart and lungs. Spot films of the ribs showed no metastases. Flat plate of the abdomen revealed a density lateral to the left psoas which appeared to be displacing the left kidney laterally. Intravenous pyelogram showed poor concentration of the dye in the left middle and lower calyces, but retrograde examination revealed only a slight dilatation of the superior calyx. No filling defects were noted. A barium enema revealed a normal colon. A gastro-intestinal series was reported as showing an irregular filling defect on the posterior wall of the proximal portion of the body of the stomach, apparently due to an extrinsic mass.

COURSE

The temperature was irregular up to 102 for the first seven days and then low grade with the highest peak at 100 thereafter. Pain in the back slowly subsided. On the sixth hospital day a small thrombosed vein was felt extending from the right ankle to the popliteal fossa. There was right calf tenderness. Homan's sign was negative. Two days later, two thrombosed veins were felt superficially on the left calf and another one on the right calf. The following day there was a mobile and nontender mass in the left upper quadrant. On the tenth hospital day thromboses of right and left cephalic veins were found.

Because of the anemia and migrating thrombophlebitis, a presumptive diagnosis of carcinoma of the body or tail of the pancreas was made, and an exploratory laparotomy was done on the 19th hospital day. A carcinoma of the stomach was found on the lesser curvature near the cardia with metastases to the regional lymph nodes and the left lobe of the liver. A biopsy of a lymph node was taken which showed occasional vague acinus formation. The nuclei stained deeply and showed typical and atypical mitoses.

The patient had an uneventful postoperative course. There were no further thromboses and pain was relieved. He was discharged on the 29th hospital day. At home his course was slowly downhill with gradual emaciation and episodes of thrombophlebitis involving the left femoral and left subclavian veins. Terminally a cord bladder was noted due either to metastatic involvement or possibly to thrombosis of spinal cord veins. He died on June 12, 1947. An autopsy could not be obtained.

SUMMARY

1. The syndrome of migrating thrombophlebitis in association with carcinoma is discussed.

2. Carcinoma of the body or tail of the pancreas is most frequently implicated in this syndrome, but carcinoma of the stomach is sometimes the etiologic factor.

3. A case of carcinoma of the stomach with symptoms of migrating thrombophlebitis and few gastro-intestinal complaints is presented in detail.

406 Centre Street
South Orange, New Jersey
197 South Centre Street
Orange, New Jersey

NAVAL RESERVE MEDICAL DIVISIONS

Announcement is made of the activation of more naval medical reserve divisions. Each will include 75 medical officers. At present these are set up for training purposes only, but in times of national emergency, personnel may be ordered to active duty individually or as units. New Jersey divisions with the medical officers in command are as follows:

3-39. Paterson, N. J.—Captain W. C. Denison, 264 Lotte Road, Ridgewood.

3-40. West New York, N. J.—Capt. Hugh McLean, 414 - 61st Street, West New York.

3-41. Westfield, N. J.—Capt. John Neilson, Jr., 533 Chestnut Street, Westfield, N. J.

3-42. West Orange, N. J.—Capt. E. W. Smalzried, 69 Woodland Avenue, East Orange, N. J.

3-43. Princeton, N. J.—Capt. L. H. Tenney, 177 Prospect Street, Princeton, N. J.

3-44. Wycoff, N. J.—Capt. H. G. Walker, 1 Everett Avenue, Wycoff, N. J.

3-45. Newark, N. J.—Capt. H. H. Kessler, 53 Lincoln Park, Newark, N. J.

3-46. Hackensack, N. J.—Capt. Eric Ryan, Saddle River, N. J.

INFANTILE PARALYSIS IN NEWARK — 1947

C. V. Craster, M.D., D.P.H., Health Officer, Newark, N. J.

Although it had been predicted that 1947 would be a high year for infantile paralysis, this has not been our experience. There were 7297 cases reported in the United States for the 39 weeks ending September 27, 1947, compared with 18,502 in the same period of 1946. These figures certainly do not bear out forecasted increase in the prevalence of this disease. In Europe, however, there have been decided increases in some countries. In the first half of the year, for example, England had 2943 cases, France 1505 cases (which was three times the 1928 median of 455 cases), and Italy had 2858 cases as compared with a median of 839.

In 1916, Newark had 1422 cases with 376 deaths. Since then we have been only slightly visited by this disease. Although some cycles of prevalence have been observed, they have not been definite enough for us to be very sure of our forecasts. All we can say is that infantile paralysis has not been unduly prevalent any year since 1916. Our greatest prevalence was in 1931 when we had a hundred cases and ten deaths. In seven other years of the past three decades we have had from thirty-five to fifty cases. Median for the eleven year period (previous to 1947) is eighteen cases. The following table gives a record of infantile paralysis cases and deaths for the previous ten years.

Year	Cases	Deaths
1937	19	1
1938	6	0
1939	5	0
1940	10	0
1941	18	3
1942	37	2
1943	13	0
1944	29	3
1945	50	7
1946	19	4

During the first ten months of 1947, we had, in Newark only fifteen cases, and no deaths. The months of prevalence have already passed and we are below the median of eighteen cases. All fifteen of our 1947 cases occurred during the summer or early fall, eight of them in September. Geographic distribution followed no specific pattern. All parts of the city were involved, and never more than one case in a single household. The fifteen cases reported in Newark in 1947 are indicated below. Case 9 had bulbar involvement; the others were all spinal cord poliomyelitis. Residual paralysis is indicated in the last column.

Case No.	Date Reported	Age (Years)	Cell Count	Paralysis *
1	July 17	2	154	None
2	Aug. 26	4	34	Leg (r)
3	Aug. 26	3	15	None
4	Aug. 28	6	192	None
5	Sept. 9	7	140	None
6	Sept. 9	11	175	None
7	Sept. 11	4	170	None
8	Sept. 12	3½	53	Legs (b)
9	Sept. 15	7	182	None
10	Sept. 15	4	182	Leg (l)
11	Sept. 19	9½	170	None
12	Sept. 23	8	42	Leg (l)
13	Oct. 1	1½	33	Leg (l)
14	Oct. 1	4	43	Leg (l)
15	Oct. 3	12	6	Legs (b)

* The letters (r) (l) and (b) indicate involvement of right, left and both legs, respectively.

These histories might indicate a general weakening of the infantile paralysis virus. There were no deaths. Paralysis was absent in seven cases and only slight in the others. Many authorities believe that infantile paralysis frequently follows tonsillectomies. Among these cases, eight had had previous operations of this type, but only one in the same year. In the others, the tonsillectomy was two or more years previous to onset of the disease. It has also been suggested that immunization against diphtheria might have some influence in preventing poliomyelitis; however, all except one in this group had been immunized.

There were also twelve cases of "suspected" infantile paralysis in 1947. Subsequent hospital observation brought about a change in diagnosis in all these cases. They had had symptoms such as a nerve or muscular involvement with a concurrent loss of function. It seems, however, wise that all such cases should re-

ceive the benefit of diagnostic study by experts. The kinds of cases which have been mistaken for poliomyelitis are varied, as indicated in the following table:

Case	Date (1947)	Age (years)	Final Diagnosis
A	May 5	14	Miliary tuberculosis
B	May 15	17	Hemophilia
C	May 15	2	Epidemic meningitis
D	Aug. 11	20	Lymphocytic meningitis
E	Aug. 18	15	Tonsillitis
F	Aug. 19	3	Fibromyositis
G	Aug. 21	10	Rheumatic fever
H	Aug. 25	2½	Cerebral concussion
J	Sept. 6	4	Tetanus
K	Sept. 9	5	Tonsillitis
L	Sept. 17	4	Myositis
M	Oct. 1	38	Hematoma

SUMMARY

Fifteen cases of infantile paralysis were reported in Newark during July, August, September and October, 1947. The cases were not concentrated in any one area but were spread widely through the city. The infections were mild and all but one were spinal cases. Seven patients had no resulting paralysis though some did have muscular weakness. All but one were under twelve years of age. There were no "repeat cases" in any one family. Among the group, of fifteen, eight had had previous tonsillectomies, but only one in the same year. Twelve cases of suspected poliomyelitis were later diagnosed as suffering from a number of other ailments. Infantile paralysis has not been unduly prevalent since 1916 when 1422 cases were reported with 376 deaths in the city of Newark.

The summer season of 1947 was remarkably free from flies and mosquitoes, a factor which may have had some influence on the reduced prevalence of poliomyelitis.

94 William Street

ABUSE OF THE TISSUE DIAGNOSTIC SERVICE

It has come to the attention of the Society of Clinical Pathologists that a few physicians are abusing the tissue diagnostic service of the American Cancer Society. This special service is intended for indigent patients. The pathologists give their services gratis, but if they are asked to work on cases where there is no real indigency, the volume and cost of the entire project mounts unnecessarily. Physicians should submit to participating pathologists, specimens from truly indigent cases only, and make other arrangements for patients who do not fall in the medically indigent class.

AN OPEN LETTER FROM THE AUXILIARY

Dear Doctor:—

Approximately 2000 of you will register at the Annual Meeting of The Medical Society of New Jersey, but not more than 250 women will attend our Convention. A sincere effort is being made by the Auxiliary to interest the women of your family in the educational work you have asked us to undertake, but there is much that you can do to assist us by your attitude towards the Auxiliary and by your insistence that your wife, your mother, your unmarried sister, and unmarried daughter attend our meeting and learn how our organization is of service to you.

Tuesday afternoon, April 27, 1948, in the solarium of Haddon Hall we are serving tea to the women folk of all the members of the Medical Society. They will find a most cordial welcome awaiting them. Won't you urge their attendance?

Sincerely,

Frances Mancusi-Ungaro,
President.

LEUKEMIA-LIKE REACTION TO ONE DOSE OF SULFADIAZINE

Leonard G. Scott, M.D., Bridgeton, N. J.

While it is known that continued intake of sulfa drugs may cause a leukemia-like reaction, such a response to a single dose is exceedingly rare, and for that reason the present case is placed on record. The patient, age 21, was admitted in active labor to the Bridgeton Hospital. Blood Wassermann and urine were consistently normal throughout pregnancy. After eight hours of labor she was delivered of a normal six pound baby. Shortly after delivery, her temperature began to rise. In the course of this rising temperature, I administered penicillin, 30,000 units every four hours. At the time her temperature was 104 degrees, I ordered sulfadiazine, 7½ grains. Since this was promptly followed by an abrupt and rapid temperature rise, the sulfadiazine was discontinued. Within two hours of this, temperature reached 106. By this time she was listless, but lungs were clear, and except for a slight nontransmitted apical systolic murmur, the heart was also clear. Blood pressure was 120/70 and rectal examination was negative. However, urinary albumin was four-plus. Chest x-ray was negative.

On the second day after delivery, temperature was 103. As she was now producing a thick, brownish, tenacious sputum, I felt it was a case of pneumonia, probably influenzal. Urinary albumin was still four-plus, and blood count on this day showed 30,000 leucocytes, of which 84 per cent were polymorphonuclears. Of the neutrophiles there were 77 per cent adults and 7 per cent bands.

On the third day, her status was about the same, and on the fourth she seemed improved. Temperature was now 99.4. However, a definite pyuria was present and there was slight jaundice of the sclera. Albumin was two plus but white cell count was up to 43,500.

She had been receiving 100,000 units of penicillin every three hours for the past three days, but the fever persisted. Indeed by the evening of the fifth day, temperature was 104, and the leucocyte count reached the extraordinary figure of 192,900! At the same time, the erythrocyte tally was down to 1,500,000. The differential leucocyte study gave one clue: the ratio of myelocytes was 75 per cent while the polymorphonuclear count was only 16 per cent. This of course suggested myelogenous leukemia. A consultant confirmed this and recommended a transfusion.

Immediately after transfusion, temperature climbed to 106 only to drop to normal within an hour. This was her first normal temperature in two weeks. The leucocyte count fell and the red count rose as indicated by the following table:

Hospital day	*White Cells*	*Red Cells*
Fifth day	192,900	1,500,000
Sixth day	89,300	2,580,000
Seventh day	53,000	2,500,000
Eighth day	34,000	3,000,000
Ninth day	12,600	3,370,000
Eleventh day	10,300	4,100,000

The percentage of myelocytes was 75 on the fifth day, 24 on the sixth day (after the transfusion) and none on the seventh day or thereafter. On the eighth day, the spleen was "doughy" and penicillin was discontinued. The patient was discharged on the eleventh day with a hemoglobin of 72 per cent, an erythrocyte count of 4,100,000 and a white cell count of 10,300.

The blood smears were checked by two different laboratories and by a clinical hematologist, and the diagnosis of myelogenous leukemia (as of the fifth day) was confirmed.

The noteworthy features of this case are the leukemia-like leucocytosis, the rapid recovery after transfusion and the fact that the reaction developed in response to a single standard dose of sulfadiazine.

496 East Commerce Street

SOURCES AND POTENCIES OF HORMONES*

W. H. STONER, M.D., Bloomfield, N. J.

The hormone manufacturer selects as source materials those substances which may be used most economically — the least expensive substances with the highest hormone yields. For the most part, endocrine glands do not retain in storage large quantities of their secretions, so that extracts of the glands and the dried glands themselves are, as a rule, not very potent. Thyroid, parathyroid, pancreas, and posterior pituitary are exceptions. Huge quantities of the glands are required for practical yields by extraction. The manufacturer, therefore, is vitally interested in manufacturing the hormones from substances giving larger yields than the glands themselves.

SOURCES

In the early days of endocrinology, Kendall isolated the active principle of thyroid and named it thyroxin. He characterized it as a complex compound containing four iodine atoms and went so far into the synthesis as to introduce three of these iodine atoms into the molecule. It remained for Harington and Barger to complete the synthesis, starting with tri-iodonitrobenzol and monomethyl-quinone. It was soon found, however, that this single active substance from thyroid was not as generally useful for hypothyroid conditions as thyroid substance, probably because other hormones beside thyroxin (di-iodotyrosine, for example) were present. Isolation, chemical characterization and synthesis of the following therapeutically useful hormones have been accomplished: epinephrine, thyroxin, estradiol, progesterone, testosterone, and desoxycorticosterone.

The starting substance for manufacture of estradiol is the group of estrogenic substances obtained from pregnant mare and stallion urines. A recent report suggests the possible use of cow manure as a practical source of estrogens. The source material for progesterone, testosterone and desoxycorticosterone is cholesterol. They may also be derived from sitosterol, stigmasteroi, other sterols, and certain plants, as sarsaparilla. The organic chemist, by changing appropriately the substituent chemical groups in the source sterol, is able to produce the desired hormone.

Lactogenic hormone, prolactin, is obtained from animal pituitary glands. Since the gonadotropic hormones cannot be obtained in practical amounts from the small pituitary gland, other sources were sought, and found in pregnant mare serum (PMS) and in human pregnancy urine (PU). In the former, follicle stimulating hormone (FSH) predominates; and in pregnancy urine luteinizing hormone (LH) predominates. These hormones, probably of placental origin, closely parallel in their actions the corresponding hormones from the anterior pituitary. Other anterior pituitary hormones, growth, thyrotropic, corticotropic, pancreatotropic, diabetogenic, fat metabolism, etc., are not yet available as potent commercial products. Source of posterior pituitary oxytocic and pressor principles is the gland itself. Source of insulin is pancreas of hog and other animals. Source of parathyroid hormone is parathyroid glands of domestic animals. Synthetic tachysterol has parathyroid-like action on calcium metabolism.

ASSAYS OF POTENCY

Prior to the synthesis of epinephrine from catechol in 1904 by Stolz and Dakin, the sole source of hormone preparations was the glands themselves. Potencies of hormone preparations obtained by extraction of endocrine glands varied widely according to the methods of extraction, preparation and storage. Their active constituents were not known chemically so that their potencies were necessarily determined by biologic assay and expressed in various units.

With the advent of synthetic hormones, pure chemical substances capable of gravimetric dosage, need for biologic assay no longer exists except for those hormones not yet chemically identified and synthesized. Before chemical identification of a hormone, potencies of its preparations were originally expressed in terms of weight of fresh or dry gland from which they were obtained. Such expressions of potency are meaningless due to wide variations in yields by different methods of extraction. A better method of expressing strength of a hormone preparation was in terms of units, namely those amounts of the various hormones which will produce

* Dr. Stoner is with the Schering Corporation. This paper was read by invitation before the Bergen County Medical Society on Sept. 9, 1947.

specifically described changes in various organisms or their tissues.

These assays are performed on small laboratory animals. Although mammals are usually employed, there are wide species differences in animals and the results of the assays sometimes cannot be transferred directly to the human species. With some of the hormones, particularly estrogens, attempts have been made at assay in the human species. Here again individual variations make such attempts exceedingly difficult and inaccurate. It is difficult to assay a product by parenteral injection when it is to be used orally. With the estrogens, for example, it has been shown that ratios of activity by oral administration to activity parenterally vary widely. The desire of hormone manufacturers for products of greatest activity is subject to question in respect to oral preparations, because total quantity ingested is of little import. With parenteral therapy, however, potency is of importance in keeping total injection volume at a minimum. The factor of economy is frequently introduced into a discussion of potency of hormones, but since cost of medication is an almost negligible part of the total cost of medical care, cost should be at least a secondary consideration in choice of hormone products.

Determination and expression of potencies of hormones is well exemplified in the case of estrogenic substances. In the early days of availability of potent estrogenic products, Allen and Doisy proposed that potency of estrogenic mixtures obtained from various sources, such as follicular fluid, pregnancy urine, amniotic fluid, placenta, etc., be expressed in rat units —one rat unit being the amount of estrogen required to produce predominance of cornified cells with some included epithelial cells and very few leucocytes in vaginal smears from 75% of a group of spayed rats. Later the Health Organization of the League of Nations proposed an international standard in which one international unit represented the estrus-producing activity of 0.1 gamma of a standard preparation of ketohydroxy estrin. Relation between this international unit and the original Allen-Doisy rat unit has been expressed variously, the rat unit being stated to have about ten times the potency of the international unit. A further complication was introduced by proposal of an international benzoate unit for estradiol benzoate. This similarly was defined as the specific activity of 0.1 gamma of a standard preparation of estradiol benzoate. Minor variations in the estrogen assay have been proposed by a score of investigators. Today only those preparations of mixed estrogens, usually referred to as estrogenic substance, require biologic assay; and the subject is at present so confused as to prevent inclusion of estrogenic substance in the recently issued United States Pharmacopoeia XIII which includes the chemically pure estrogens—estradiol, estradiol benzoate and estrone, and their preparations, and the widely used ersatz estrogen, diethylstilbestrol, and its preparations—capsules, injection and tablets. Dosages of these chemically pure substances are expressed in terms of weight, usually milligrams, although a statement concerning their rat or international unitage is usually given as well. The problem of expressing potencies of hormones parallels exactly the development of expressions of potencies of vitamins. Units are necessary only until the chemically pure substance is available, either by extraction or by synthesis.

Similarly, potencies of androgens were first expressed in terms of bird units, meaning that amount which would produce a certain growth effect on the comb of the capon or of the immature cockerel. As soon as testosterone was identified as the androgen elaborated by the testis, it was no longer necessary to use units since potencies of androgenic preparations were best expressed in milligrams of testosterone, or its derivatives. The minor ineffectual androgenic preparations, not pure testosterone, are still labeled in terms of bird units.

The original rabbit unit of corpus luteum activity is now replaced by milligrams of the pure steroid hormone, progesterone, and its derivatives, and milligrams of desoxycorticosterone acetate have replaced the former biological unitage expression for potencies of adrenal cortical extracts. Adrenal medulla preparations, epinephrine, its derivatives and substitutes are assayed by their effects in rais-

ing blood pressure in the dog. Parathyroid preparations are assayed by their effects of increasing blood calcium in the dog. The several hormones obtained by extraction from the anterior pituitary are assayed as follows: prolactin by its effect in increasing the weight of the crop gland in the pigeon; growth hormone by weight increase in rats and mice; thyrotropic hormone by weight increase in thyroid of day-old chicks; adrenotropic hormone by weight increase and histologic repair of adrenals in hypophysectomized rats. Anterior pituitary-like gonadotropic hormone from pregnancy urine is assayed by its effect upon vaginal smear and increase in ovarian weight in rats. Anterior pituitary-like gonadotropic hormone from pregnant mare serum is assayed by its effect upon ovarian weight in rats. Posterior pituitary is assayed by its effect on increasing contractions of guinea-pig myometrium. Insulin is assayed by its effect in lowering blood sugar in the rabbit. All attempts to date to prepare synthetic insulin or substitute insulin-like substances have failed. United States Pharmacopoeia XIII lists the following steroid hormones and specifies tests for their purity: estradiol, estrone, estriol, progesterone, anhydrohydroxyprogesterone, testosterone, methyltestosterone, and desoxycorticosterone. The following USP hormones are assayed biologically: insulin, posterior pituitary, parathyroid, epinephrine. USP thyroid, thyroxin, and diethylstilbestrol are assayed chemically.

At USP headquarters in Philadelphia are available the following reference standards for biologic assays and comparison of hormones: diethylstilbestrol, epinephrine, estrone, insulin, methyltestosterone, and posterior pituitary. These reference standards are available to accredited workers in this field.

SPECIFICATIONS AND STANDARDS

The Federal Food and Drug Administration and the Federal Trade Commission effectively protect the physician against fraudulent medicinal products. Before the strengthening of these official federal agencies, the Council on Pharmacy and Chemistry of the American Medical Association guided the physician toward satisfactory products, although the Council had no legal authority to enforce its rules and recommendations. The United States Pharmacopoeia and the National Formulary are the official federal standards for specifications of drugs. These standards are recognized by federal and state drug acts as the basis for law enforcement. New drugs, before they are marketed, are scrutinized by the Food and Drug Administration, and advertising is reviewed by the Federal Trade Commission, so that the physician is now adequately protected by official governmental agencies against inferior preparations. However, there are still a few physicians, hospital formulary committees, and purchasing agents, even for governmental departments, as army and navy, who insist that a Council-accepted product is to be preferred to the identical non-Council-accepted competitive product, even though it may be listed in the USP.

2 Broad Street

GRADUATE INSTITUTE IN PHILADELPHIA

The Twelfth Annual Postgraduate Institute of the Philadelphia County Medical Society will be held at the Bellevue-Stratford Hotel, April 20-23, 1948.

Among the topics to be covered are problems in obstetrics and gynecology, newer drugs and procedures, surgery of the ambulatory patient, fractures, the painful breast, neuropsychiatric disorders, problems of the aged, the acute abdomen, gastrointestinal disorders, and otolaryngologic problems.

In addition to the regular morning and afternoon programs there will also be two evening sessions at the Society Building on the subjects of cancer and pediatrics.

Technical exhibits will be important features of the sessions. Registration fee for the entire meeting is five dollars. A copy of the preliminary program and any further information may be secured by writing to Gilson Engel, M.D., 301 South 21st Street, Philadelphia 3, Pa.

STATE ACTIVITIES

PROGRAM
OF THE
182nd ANNUAL MEETING
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Monday, Tuesday, Wednesday, Thursday, April 26, 27, 28, 29, 1948
Haddon Hall, Atlantic City

ROOM RESERVATIONS

Write for your reservation to Mr. George J. Turcotte, Haddon Hall, Atlantic City; designate your attendance at the Medical Society meeting, the date you will arrive and the rate desired. Convention rates are:

Single Rooms with bath—$7, $8, $10.

Double Rooms with bath—$10, $12, $14, $16, $18 (twin beds).

(Add $6.00 per day per person for American Plan meals.)

EXHIBITS

For the first time since 1942 the Scientific Exhibits will again take their place as one of the feature attractions of our meeting. The Committee has numerous applications for exhibit space and only the best will be presented.

Educational Exhibits will also be shown. These are always interesting and it will be well worthwhile for you to spend a few minutes reviewing each one.

As usual, all space in the Technical Exhibits was reserved within a few days after floor plans were issued, and we have had to reject several applications because of lack of space. The New Jersey meeting is popular with the technical exhibitors; the area is compact, the doctors friendly and the convention is sociable. These exhibitors "pay the freight" on our meeting and to show our appreciation, every member who attends the meeting is urged to visit the exhibit hall and register at the booths.

BANQUET RESERVATIONS

The banquet will be held at 7:30 p. m., Wednesday, April 28, 1948. Tickets at $6.00 per plate may be reserved in advance by sending your check to the Executive Offices, Trenton.

Detailed program will appear in the April Journal.

DAILY SCHEDULE

SUNDAY, APRIL 25, 1948

8:00 p. m.—Finance and Budget Committee
Rowsley Room, 1st floor

MONDAY, APRIL 26, 1948

10:00 a. m.—Board of Trustees
Rowsley Room, 1st floor
Judicial Council
Bakewell Room, 1st floor
2:00 p. m.—House of Delegates
Viking Room, 13th floor
6:30 p. m.—Fellows' Dinner
Rowsley Room, 1st floor
8:30 p. m.—Nominating Committee
Bakewell Room, 1st floor

TUESDAY, APRIL 27, 1948

10:00 a. m.—Scientific Sections:
Medicine
Rutland Room, 1st floor
Pediatrics
Viking Room, 13th floor
Eye, Ear, Nose and Throat
Mandarin Room, 13th floor
1:00 p. m.—Auxiliary Executive Board
Solarium, Lounge floor
2:00 p. m.—Scientific Sections:
Gastro-Enterology
Mandarin Room, 13th floor
Surgery
Rutland Room, 1st floor
Neuropsychiatry
Viking Room, 13th floor
Obstetrics and Gynecology
Benjamin West Room, 13th floor
3:30 p. m.—Auxiliary Tea
Solarium, Lounge floor
4:15 p. m.—School Health Program Conference
Viking Room, 13th floor
6:30 p. m.—Fellowettes' Dinner
Bakewell Room, 1st floor
8:00 p. m.—Reference Committees
13th floor

WEDNESDAY, APRIL 28, 1948

9:30 a. m.—Scientific Sections:
Clinical Pathology
Tower Room, 13th floor
Radiology
Viking Room, 13th floor
Chest Diseases
Mandarin Room, 13th floor
Auxiliary Business Session
Solarium, Lounge floor
12:00 noon—House of Delegates (election)
Viking Room, 13th floor
1:00 p. m.—Luncheons:
Auxiliary
Rutland Room, 1st floor
New Jersey Medical Women's Association
Benjamin West Room, 13th floor

Joint Committee on Professional Relations
Green Room, 13th floor
New Jersey Society of Chest Physicians
Bakewell Room, 1st floor
2:00 p. m.—General Session
Viking Room, 13th floor
3:00 p. m.—Auxiliary Business Session (con't.)
Solarium, Lounge floor
4:15 p. m.—New Jersey Rheumatism Association
Mandarin Room, 13th floor
6:15 p. m.—Social
Rutland Room, 1st floor
7:30 p. m.—Dinner-Dance
Carolina Room, Chalfonte Hotel

THURSDAY, APRIL 29, 1948
8:00 a. m.—Auxiliary President's Breakfast
Bakewell Room, 1st floor
10:00 a. m.—Scientific Sections:
Venereal Disease Control
Benjamin West Room, 13th floor
Diseases of Metabolism
Viking Room, 13th floor
Anesthesiology
Mandarin Room, 13th floor
Orthopedics
Tower Room, 13th floor

Auxiliary Executive Board
Solarium, Lounge floor
12:30 p. m.—Luncheon, New Jersey Orthopedic Society
Bakewell Room, 1st floor
1:30 p. m.—House of Delegates
Viking Room, 13th floor

TRUSTEES' MEETING

The regular meeting of the Board of Trustees was held on January 11, 1948. Present were: Dr. Lance, who presided in the absence of the chairman, Dr. Norton, Dr. Dodd, Dr. Johnsen, Dr. Schaaf, Dr. Green, Dr. Sica, Dr. Wood, Dr. Costello, Dr. Allman, Dr. Hornberger. Also present by invitation, were: Dr. Hurff, Dr. Londrigan, Dr. Scott, Mr. Bryan and Mrs. Madden.

REPORT OF THE PRESIDENT

The resolution passed by the Board at its November meeting, directing the Committee on Post-Graduate Education to circularize the members of the Society as to their approval of the establishment of a medical college under the auspices of the State University, was reconsidered.

After discussion, the Board concurred that such circularization was unnecessary, inasmuch as the Society has already officially endorsed the establishment of a medical school under State University auspices by its action on November 24, 1946.

Dr. Schaaf moved the Board rescind its action of November 16 authorizing such survey, and that Rutgers University be notified of the Society's approval of the project. Motion seconded and carried unanimously.

A resolution from the Middlesex County Medical Society requesting the establishment of a Grade-A Medical School by the State University was read.

No action was deemed necessary on this resolution as the Society has already endorsed the principle of a medical school under State University auspices, supported by tax funds.

The four points of difference to be reconciled between The Medical Society of New Jersey and the Department of Institutions and Agencies, on the *Manual of Hospital Standards,* have been adjusted.

In Section 10 "Special Regulations for New Hospitals", a new paragraph has been added. It provides that when any new hospital is to be constructed, the organizations and the individuals planning the establishment of the new hospital should conduct a preliminary survey, including a canvass of the physicians in the area and the reactions of the county medical society.

President Schaaf stated that with the acceptance of the revised *Manual of Standards* by Commissioner Bates, the Society's interests would be fully protected.

The Medical Society of New Jersey has been invited by Commissioner Bates to appoint an Advisory Committee to the Hospital Licensing Board. The function of this committee will be to interpret the views of the Society and the general attitude of the profession to the Board in its work of administering the Hospital Licensing Act. President Schaaf was authorized to designate the members of the Advisory Committee to the Hospital Licensing Board. President Schaaf announced the following had been selected: Dr. Thomas W. Harvey, Dr. Earl J. Halligan and Dr. C. Byron Blaisdell.

On November 22 the new agreement with Veterans Administration, dispensing with the services of a liaison officer, was signed. It is understood if, at the termination of the con-

tract such an officer is found to be necessary, the contract may be renegotiated.

Medical Service Administration is now no longer concerned with Veterans Administration. The examining boards are not functioning now and will not unless the Government requests that their services be resumed.

The report on the *Manual of Standards of Training Schools and Curriculum for Practical Nurses* was presented to the members of the Board. (Copy on file in the Executive Offices.) President Schaaf stated it was impossible for this matter to go through the regular channels of the Welfare Committee because of the necessity for immediate action.

The Board concurred in the report of the committee. Dr. Costello moved that President Schaaf be empowered to approve the *Manual of Standards for Practical Nurses,* providing the points of difference listed in the report can be reconciled. Motion seconded and unanimously carried.

As Chairman of the Committee on Medical Defense and Insurance, Dr. Hurff reported that his Committee has studied various insurance policies and are in agreement that none are on a par with, nor better than, the policy now endorsed by the State Society.

Other insurance companies have also requested permission to advertise their policies in the JOURNAL.

The Committee recommends that advertisements of insurance companies in the JOURNAL be limited to those companies that have received the endorsement of the State Society.

Dr. Allman moved the matter of publishing advertisements of other insurance companies in the JOURNAL be left in the hands of the Publication Committee.

Dr. Norton offered the following amendment which was accepted: provided also that the stipulated advertising have the approval of our own Committee on Insurance. The amended motion was unanimously carried.

At the request of the President, Mr. Bryan briefly reported on the joint meeting of the Advisory Committee on Crippled Children with representatives of the Crippled Children Commission. It was the opinion of the Advisory Committee that a better understanding between the Society and the Commission now exists as a result of this meeting and that the Society should have no objection to the Commission's program of physical re-education.

Dr. Scott supplemented Mr. Bryan's remarks stating that the Society's attitude toward clinics should be clarified. He suggested that the Board enunciate its policy clearly, since the policy of the State Society should not be interpreted to apply to the education and physical training of children.

Dr. Schaaf presented a letter from Essex County Medical Society protesting the nonacceptance of the attending surgeon's signature on Crippled Children Commission forms requesting the purchase of prosthesis. Such forms require the signature of an orthopedist recognized by the Commission. It is felt that if the surgeon is accepted to do the work, his signature should be accepted on the form.

The Executive Officer was instructed to discuss this matter with the Crippled Children Commission and ascertain the reasons for the requirement, inform the Commission that the signature of the attending surgeon should be adequate, and report back at the next meeting.

The Board directed that a supplemental interpretation be issued on the policy of the State Society *re* clinics, stating this resolution is not intended to interfere with existing educational and physical training of crippled children.

Dr. Scott was authorized to attend the Conference on Rural Health, the Conference on Medical Service and the Conference on Medical Education and Licensure in Chicago, February, 1948.

The newly organized New Jersey Sociologic Association has requested approval by The Medical Society of New Jersey.

Dr. Schaaf moved the Board inform the sponsors that The Medical Society of New Jersey is not willing at this time to endorse this program; and that the New Jersey Neuropsychiatric Association be so notified. Motion seconded and unanimously carried.

At the January meeting of the Advisory Committee on Cancer Control, a unit system of payment for laboratory examination of clinic patients was approved. The value of the unit at present is to be fifty cents. The Committee requests approval by the Board of this unit method of determining fees and the development of a fee schedule acceptable to radiologists and hospitals.

Upon motion by Dr. Schaaf, seconded and carried, the unit system of charges as submitted by the Committee was approved.

Chairman Crowe named Doctors Norton, Lance and Green as a Special Committee to consider the matter of a contract for the Executive Officer.

Opinion from counsel has been received to the effect that membership in the Chamber of Commerce would not jeopardize our tax-exempt position, and application for membership for 1948 has been made.

Mr. Bryan requested opinion from the Board

as to his status with other organizations interested in medical matters.

Upon motion by Dr. Schaaf, seconded and unanimously carried, the Board went on record as favoring the affiliation of the Executive Officer with all organizations engaged in the promotion of public health and welfare; the Executive Officer to be instructed to seek such affiliations.

Through the Executive Officer, the Morris County Medical Society requested the Board of Trustees to seek a distinctive license plate for medical doctors. The Commissioner of Motor Vehicles viewed the request unfavorably. The present system of designating counties by letters would have to be abandoned if special lettering were provided for special groups. The system has worked out so satisfactorily from the standpoint of law enforcement that the Department would be loathe to change it. If physicians were provided with special designation the Department would be swamped with requests from other groups for similar designation.

The Board was informed of a forthcoming private hearing on alleged discrimination in appointment of Negro physicians and nurses to hospital staffs throughout the state, to which The Medical Society of New Jersey will undoubtedly be invited to send representatives.

Upon motion by Dr. Allman, seconded and unanimously carried, the choice of our representative to such hearing, if and when invitation from the Commission is received will be left in the hands of the President.

At the meeting of the Committee on Post-Graduate Education on November 30, the following recommendations were approved:

1. That the Rutgers Plan for Graduate Education, operated as an experiment in Cooper Hospital in Camden during the past year, be extended to other communities; such recommendation together with a resume of the experience at Cooper Hospital to be sent to Rutgers.

2. Approval of the Rutgers graduate educational program for county societies during the coming year; the Committee to hold a meeting in the near future of county society representatives to explain the programs available and stimulate their use.

3. Request for courses on medico-legal problems and methods of estimating disabilities under the Workmen's Compensation Law to be considered at a joint meeting of the Committee on Post-Graduate Education and the Advisory Committee on Workmen's Compensation.

4. That the Committee accept, with the approval of the Board of Trustees, the designation of this Committee by Rutgers University as its medical advisory committee.

Upon motion by Dr. Schaaf, seconded by Dr. Wood and unanimously carried, the Committee on Post-Graduate Education was authorized to accept designation as the medical advisory committee to Rutgers University.

Upon motion, seconded and unanimously carried, the report of the Committee was accepted.

A resume of the ad interim meeting of the A.M.A. House of Delegates in Cleveland, January 5, 6, 1948, was presented for the information of the Board. This was published on page 84 of the February JOURNAL.

At the request of Dr. Lance, Dr. Dodd presented the report of the special meeting with representatives of the New Jersey Pharmaceutical Association.

The committee recommended the approval of the resolution of the Welfare Committee "That facilities be augmented at the State Department of Health to meet the modern need of adequate diagnosis and control of syphilis".

Upon motion by Dr. Sica, seconded and unanimously carried, the resolution was approved as presented.

The Committee recommended the approval of the resolution of the Welfare Committee with one amendment (amendment italicized below).

"That all appropriate efforts be continued by The Medical Society of New Jersey and the State Department of Health to obtain additional appropriations for free distribution of Penicillin in Oil and Beeswax by the State Department of Health for the treatment of patients with acute gonorrhea and syphilis in the infectious stages by physicians in their private offices in areas where public *VD clinics are not available,* providing the patient is unable to pay for the same in the opinion of the attending physician."

Upon motion by Dr. Sica, seconded and unanimously carried, the resolution, as amended, was referred back to the Advisory Committee on Venereal Disease Control where it originated.

A comprehensive report on two matters referred to Medical Service Administration by the Board of Trustees was presented by Dr. Scott, together with recommendations. The report begins on page 126 of this JOURNAL.

With regard to the recommendation of the Board that some remuneration be paid by the Crippled Children Commission to physicians doing work for the Commission; and that MSA study the problem with a view to setting up a plan similar to the plan now operated for the City of Newark, it is recommended that MSA meet with the Advisory Committee on

Crippled Children and evolve a contract or "memorandum of understanding" with the Commission to which will be attached a guiding fee schedule governing the payment for physicians' services; such fees to apply only to services rendered hospitalized patients and not treatment rendered in any of the out-patient clinics sponsored by the Commission.

At the request of the Board that MSA study the problem and set up a state-wide plan for control of the payment of services, it is recommended that MSA continue negotiations with the State Board of Child Welfare with the objective of establishing a plan for the care of dependent children in Essex County in accordance with the "Principles of Cooperation" approved by the House of Delegates in 1947 and patterned after the City of Newark Medical Plan; except that it would include care rendered in physicians' offices and in the hospital.

Upon motion by Dr. Schaaf, seconded and unanimously carried, the Board commended Dr. Scott upon the excellence of his reports.

The following recommendations, presented by the Sub-Committees on December 14, 1947, were approved by the Welfare Committee on the same day; they are referred to the Board of Trustees for consideration and action.

1. That the Board of Trustees give consideration to the advisability of instructing Delegates of this Society to introduce resolutions at the House of Delegates of the A.M.A., designed to amend S.545, the Taft-Smith-Ball-Donnell Bill, so as to make grants-in-aid *applicable only to those states which can demonstrate need of Federal financial assistance* to carry out the purpose of Title VII.

Since the meeting of the A.M.A. House of Delegates preceded this meeting of the Board, the resolution was drafted and sent to the New Jersey Delegates by President Schaaf, with the approval of the Chairman of the Board, with instructions to introduce it at the A.M.A. meeting. (No action was taken on this resolution by the A.M.A.)

Upon motion by Dr. Costello, seconded by Dr. Green and unanimously carried, the Board approved the resolution and the action of the President.

2. Upon motion by Dr. Schaaf, seconded by Dr. Johnsen and unanimously carried, the amended Standards to Decrease Neo-Natal Mortality * were approved, and the Secretary directed to send a copy of the Standards to the superintendents and chiefs of staff of all New Jersey hospitals.

3. "That the sending of ambulatory private patients to hospitals for x-rays, laboratory examinations and physical therapy treatment be discouraged where facilities are available in private physicians' offices. Nothing in this recommendation shall be interpreted as interference with existing public health studies, mass x-rays or studies, or clinic care of the indigent."

Upon motion by Dr. Schaaf, seconded and unanimously carried, the Board endorsed in principle the recommendation and instructed the Secretary to so notify all hospitals.

4. "That we not approve the formation of the New Jersey Chapter of the National Society for Crippled Children and Adults as presently proposed; that further consultation be held by representatives of the New Jersey Hospital Association, The Medical Society of New Jersey, and the National Society for Crippled Children and Adults, Inc., as to how a New Jersey Chapter can be set up for the best interests of the public; copy of this recommendation to be sent to the New Jersey Federation of Women's Clubs, the National Society for Crippled Children and Adults, Inc., Miss Brokaw of the New Jersey Chapter, and the New Jersey Hospital Association."

Mr. Bryan reported that at a subsequent meeting of the Advisory Committee on Crippled Children, strong objection was taken to the program for rehabilitation workshops as described by the National Society, on the ground that it violates the two main policies of The Medical Society of New Jersey regarding such extra hospital services:

1. It fails to provide continuous and direct medical supervision of medical processes.
2. It sets up medical services specifically in physical therapy which hospitals are amply able to provide and which there is no justification in most communities for anyone to set up separate services.

The Committee expressed itself as being wholly in favor of extending occupational therapy facilities throughout the state and indicated that it would urge full support by The Medical Society for this program, but that it strongly opposes the physical therapy aspects of the plans of the National Society.

Upon motion by Dr. Schaaf, seconded by Dr. Dodd and unanimously carried, the Board approved the recommendation of the Welfare Committee and instructed the Executive Officer to notify the agencies concerned of our point of view.

5. "That Public Health Week in 1948 be authorized for November 8 to 12, and that the Board request Governor Driscoll to proclaim the designated period as State Health Week."

Upon motion by Dr. Schaaf, seconded and unanimously carried, the Board concurred in

* Printed on page 34 of the January 1948 JOURNAL.

this recommendation and instructed the secretary to notify the Governor.

6. "That the following five purposes of the New Jersey Heart Association be approved:

(1) The study, dissemination and application of knowledge concerning the causes, treatment and prevention of diseases of the heart and circulation.
(2) The improvement of facilities and services within New Jersey for the diagnosis and treatment of such diseases.
(3) Professional education of physicians, nurses, medical social workers and teachers, so that each of these groups may be in a position to accept the responsibilities involved in developing a community program.
(4) Lay education for the guidance of those needing services; and, when a community program has been established, for the dissemination of information which will urge patients to seek early medical advice.
(5) Public relations and fund-raising campaigns designed to publicize and support the program of the local association, and also to provide funds to be distributed on a national basis for research in cardio-vascular disease."

Upon motion by Dr. Costello, seconded by Dr. Wood and unanimously carried, the Board approved in principle the five purposes of organization of the New Jersey Heart Association.

7. That a resolution on better school health programs be presented by the New Jersey Delegates at the January meeting of the A.M.A.

Dr. Schaaf reported that since the Board had not taken a stand on this matter, the resolution was sent to the New Jersey Delegates prior to the A.M.A. meeting for their information; introduction of the resolution was left to their discretion.

Dr. Costello reported that the Delegates felt the resolution should be clarified and that it had not been introduced.

Upon motion by Dr. Schaaf, seconded by Dr. Wood and unanimously carried, the resolution was tabled for further consideration.

8. "That we endorse in principle the giving of booster shots to pre-school children for whooping cough control as recommended by the State Department of Health."

Upon motion by Dr. Wood, seconded and unanimously carried, the Board concurred in this recommendation.

9. "That The Medical Society of New Jersey, in cooperation with the New Jersey Tuberculosis League, ask Doctors Doppler and Douglas, together with Mr. Bryan, to visit counties which have no established tuberculosis facilities and recommend to their county medical society that arrangements be made so that physicians may send their patients for chest x-rays at any time, in accordance with the "Somerset Plan".

Upon motion by Dr. Wood, seconded and unanimously carried, the Board concurred in this recommendation.

The following policy statement of the New Jersey Tuberculosis League, upon motion by Dr. Schaaf, seconded by Dr. Costello and unanimously carried, was tabled for further study.

11. "For each county there should be suitable and adequate facilities for finding cases of tuberculosis and for the diagnosis and care of patients in need of treatment. These facilities should include a modern health education program, laboratory service, x-ray and diagnostic clinics, institutions for treatment, social service and a program of rehabilitation. All these should be available to the public and to tuberculosis patients in any stage of the disease, and without regard to the capacity to pay."

11. "That we ask each county society to act as co-sponsor of *Health Hints* within its own jurisdiction, and request the editor to insert the name of the county medical society in the signature note introducing each release."

Upon motion by Dr. Schaaf, seconded by Dr. Sica and unanimously carried, the Board concurred in this recommendation.

12. "That the distribution of *Health Hints* in mimeographed form be authorized for school papers and for science and hygiene teachers in the schools, wherever the superintendents of schools will approve the suggestion."

Upon motion by Dr. Sica, seconded by Dr. Johnsen and unanimously carried, the Board concurred in this recommendation.

13. "That a quarterly one-page letter to lay organizations throughout the state be authorized. The letter will describe the public projects and policies of the State Society, offering spot notices for their own bulletins."

Upon motion by Dr. Wood, seconded and unanimously carried, the Board concurred in the recommendation.

Dr. Sica reported that he had been appointed chairman of a committee to draft resolutions on the death of Dr. Scammell, together with two Mercer County members of his own selection, by the Chairman, Dr. Crowe. The resolution is printed on page 130 of this JOURNAL.

CORRESPONDENCE

1. Replies from the chairmen of the School Health, Child Health and Public Health Committees signify their approval of the school health program and its assignment to the Auxiliary for implementation.

2. A letter was received from the A.M.A. congratulating New Jersey upon its contribution to the medical profession of America in developing a positive project for implementation of the national health program.

3. The Crippled Children Commission acknowledged our recommendation that some remuneration be paid by the Commission to physicians doing work for it; stated that the matter would be submitted to the Commission at their meeting in October 1948. This was referred to Dr. Scott for follow-up in connection with the study of this problem being made by Medical Service Administration.

4. A copy of the resolution disapproving hospitals requesting physicians voluntarily or otherwise to contribute fees for hospital admissions was sent to the New Jersey Hospital Association and all New Jersey hospitals.

All replies concurred in this resolution. The Hospital Association also pointed out that the American Hospital Association on September 21, 1947, adopted the following resolution:

> "That the American Hospital Association condemn and disapprove medical staff assessments by the hospital for the financial support of the day by day operation of the hospital and recommend to its membership the tension in the governing board of the responsibility for securing from the community adequate financial support for the operation of the hospital."

Copies of the replies will be sent to the Chairman of the Advisory Committee on Hospital Relationships for his information and study.

PROFESSIONAL RELATIONSHIPS COMMITTEE

The following medical members of this committee were appointed by the Chairman:

Dr. Harrold A. Murray, Chairman
Dr. D. Ward Scanlan
Dr. Sigurd W. Johnsen
Dr. Irvin E. Deibert
Dr. Spencer T. Snedecor

A letter from Commissioner Harper announced the reappointment of Drs. William K. Harryman and Marcus H. Greifinger to the Commissioner of Labor's Advisory Committee on Workmen's Compensation.

The revised definition of a Public Health Center was adopted by the Hospital Advisory Council of the State Department of Institutions and Agencies on December 29, 1947.

NURSES TRAINING SCHOOLS

Copies of this resolution were sent to the Governor, all legislators, the New Jersey Hospital Association, the Nurses Association and the Commissioner of Institutions and Agencies.

Numerous replies were received. The Hospital Association was "gratified at the firm and forward looking stand taken by The Medical Society". Some legislators asked if the Society would endorse specific type of tax to defray the cost of program outlined; to which President Schaaf replied that we have not undertaken the matter of indicating where taxes should be levied, but would be cordial to a proposal for special taxes levied on all types of luxury items. The Governor replied that subsidization of nurses training schools is most likely of some immediate achievement. He would be pleased if the Society conferred with President Clothier and other Rutgers authorities to determine how such a project can be fitted into their regular curriculum. One legislator asked: "is the Society trying to socialize nurses?"

Congratulations were sent to Dr. Joseph E. Raycroft, an honorary member, on his 80th birthday by President Schaaf on behalf of the Board. A note of thanks was received from Dr. Raycroft.

An acknowledgment of flowers sent to the funeral of Dr. Scammell was received from his daughter, Mrs. George H. Walton.

Upon motion by Dr. Schaaf, seconded and unanimously carried, the Board approved the action of the Executive Offices in sending flowers to the funeral of Dr. Scammell in the name of the Board of Trustees.

ADVISORY COMMITTEE ON NUTRITION

The recommendation of the Advisory Committee on Nutrition, approved by the Welfare Committee on September 14, was reconsidered:

"That the Board of Trustees request colleges and universities of this state to require public health education as a part of entrance requirements to colleges, to be effective as of 1950." This recommendation had been tabled at previous Board meetings pending clarification of the resolution.

Upon motion, seconded and unanimously carried, the recommendation and clarification (received from Dr. Kalb, Chairman of the Committee) were referred to a special committee for study and report at the next meeting of the Board; members of this special committee to be appointed by the Chairman of the Board.

RADIO PROGRAM

Mr. Bryan requested the Board approve the proposal of "Radio Providence Producers" to interest stations in New Jersey and sponsors (acceptable to The Medical Society of New Jersey) to extend the weekly coverage of the program *Doctor's Orders*. The only responsibility of The Medical Society, on a state and county level, will be to enlist the participation of local physicians to read scripts from each local outlet of this program during the final five minutes of the program period.

The Board authorized the Public Relations Committee to proceed with this program, leaving the selection of a sponsor to the discretion of the Committee with the provision that such sponsor be endorsed by the Board of Trustees; the Executive Officer to be authorized to aid in the production of this program as much as possible.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY
MEDICAL-SURGICAL PLAN OF NEW JERSEY

A REPORT TO THE BOARD OF TRUSTEES OF THE MEDICAL SOCIETY OF NEW JERSEY

JANUARY 11, 1948

At the September meeting of the Board of Trustees, Dr. Lance, chairman of a special committee, presented the following report for approval:

Old Age Assistance—The Committee recommends that Medical Service Administration study this problem and set up a state-wide plan for control of the payment for services.

Board of Child Welfare—The Committee recommends that the Medical Service Administration study this problem and set up a state-wide plan for control of the payment for services.

Crippled Children Commission—The Committee recommends that some remuneration be paid by the Crippled Children Commission to physicians doing work for the Commission, and that Medical Service Administration study the problem with a view to setting up a plan similar to the plan now operated for the City of Newark.

We are not ready to report upon the Old Age Assistance problem, but wish to report upon the other two problems assigned to us.

In 1921, the Elks introduced in New Jersey a program for the care of crippled children. In 1926, this became a temporary State Commission on Crippled Children, and two years later, it became a permanent, official Commission of the state government. On its active rolls, there are now 13,000 children. These are children of indigent and low income families in need of orthopedic treatment or surgery, plastic surgery, physical training or rehabilitation.

The Commission acts as a coordinating agency in providing the necessary hospitalization and professional care of these children from money available from various sources. It operates a travelling diagnostic clinic two days of each month at a different location in the state. It conducts treatment centers for the care of children afflicted with cerebral palsy at Elizabeth, Trenton, Camden, Long Branch and Passaic. Of the 13,000 children on their rolls, 460 were admitted to hospitals last year for a total of 22,769 hospital days. The Commission provides home nursing services through offices at Jersey City, Newark, Perth Amboy and Camden, the services being furnished by local visiting nurses associations at $1.25 per visit. Such services for 3,169 children were provided last year. During the past year they conducted a rheumatic heart disease clinic at St. Michael's Hospital in Newark and hope to expand this activity.

Funds for the support of the program are derived from federal, state and county government, the National Foundation for Infantile Paralysis and from the Elks. Anticipated 1948 income is:

Federal matching funds	$ 89,871
Federal funds	15,422
Special federal funds	80,000
	$185,293
State government	50,000
	$235,293
State Govt. Addit. Request	50,000
	$285,293

In addition, each county appropriates money (up to $30,000), but this is usually expended directly by the freeholders for care rendered children in the respective counties to supplement the Commission money. In Cumberland, Warren and Middlesex the appropriation is

paid directly to the Elks for their county program. The National Foundation for Infantile Paralysis makes appropriations for specific purposes to supplement Commission or county money, or as part payment of costs on an individual case basis.

Several years ago, $10,000 of their budget was set aside for payment of surgeons. A committee was appointed to evolve a fee schedule, but the committee never rendered a report. For this reason, surgeons have never been compensated for their work except in Union County where they are paid directly by the freeholders out of funds appropriated for the Commission. The Acting Director, Mrs. Joseph Buch, believes the Commission will favor payment of surgeons and it will be considered at the October meeting.

The Crippled Children Commission acts largely as a coordinating agency in providing necessary care to these children, the actual payment for these services being made from several sources. Under such conditions it would be impractical for Medical Service Administration to play a part in the program. It would act as a fifth wheel rather than simplifying the problem.

The type of surgery necessary in the care of these children is highly specialized and must be rendered by men highly qualified in certain specialties, mostly orthopedics and plastic surgery. The principle of "free choice of physician" is hardly applicable. There are at present 35 orthopedic surgeons, 11 plastic surgeons and one neurologist on the panel of the Commission. Each child is treated very much on an individual basis, not always by common standards of surgical technics possible to enumerate as specific items on a fee schedule. Since services rendered by physicians in the care of these children should be on a strictly individual basis (in accordance with each child's specific needs) arrangements for payment of services should be as arranged between the physician and the organization sponsoring the care of the child.

It is recommended that Medical Service Administration meet with the Crippled Children Committee of the Society and evolve a contract or "memorandum of understanding" with the Commission with an attached guiding fee schedule governing the payment for physician's services. It is recommended that such fees apply only to services rendered hospitalized patients and not treatment rendered in any of the out-patient clinics sponsored by the Commission.

STATE BOARD OF CHILD WELFARE

This agency was organized in 1898 as the State Board of Children's Guardians. Recently —in July 1947—its name was changed to State Board of Child Welfare. In addition to its Trenton Headquarters, it maintains district offices in Newark, Jersey City, Paterson, Hackensack, Morristown, New Brunswick, Red Bank, Trenton, Camden, Bridgeton and Cape May Court House.

There are two sub-divisions of their organization, each dealing with a specific type of problem. *The Home Life Assistance Division* deals with continuing family units in which the mother is still in the picture and caring for her children, the father being dead, imprisoned, deserted, a drunkard or mentally ill or not responsible for the welfare of his family. The Board takes the place of the breadwinner, providing a home in which the mother cares for her own children. The Board gives the mother a monthly grant, the amount being computed on a basis of minimum budget standards. This does not include money for medical, dental or hospital care. It follows the family until the children are 16 years of age, or 18 years of age if still in school. This part of the program is supported by federal, state and county funds.

A Department of Dependent Children provides for children, up to 21 years of age, in cases where there has been a breakdown in the family and the children have been committed to the Board by the Court as legal guardians. These children are placed in foster homes and effort is made to create a wholesome family atmosphere for each child. The boarding rate is $35.00 a month per child. Clothing and medical care are provided in addition.

At present there are 4000 mothers and 10,000 children in the Home Life Department and 10,000 children in the Dependent Children Department for a total of about 24,000 persons. For the Home Life Department the federal government provides half the costs up to 50 per cent of $24.00 per month for each child. The remaining cost is divided between state and county. Federal funds are not contributed to cost of medical care. Eligibility is determined by the County Welfare Board. Medical care is payable upon order of the County Welfare Board. In the Dependent Children Department, federal funds are not available and costs are paid jointly by state and county.

Expenditures for both departments in 1946 were $6,000,000, exclusive of administrative cost. The administrative cost is paid by the state except for the Home Life Department for which the federal government provides 60 per cent.

Their medical program is comprehensive. I would say it is a good program, though it

does contain defects which they are anxious to correct. It is being evolved with the advice of a Committee including three members of the Society: Dr. Harrold Murray, Dr. Samuel Blaugrund and Dr. Wilson Guthrie.

In the Home Life Department, the federal grant must be expended by payments made directly to the family. The federal government will not acknowledge payment of their funds to a vendor—and in this case the physician is considered a vendor. For this reason, in the past, the mother would report her medical costs each month and her budget for the month would be increased to cover this cost. She might or might not pay the doctor. She might expend the additional money for what she considered necessary for her children. This explains why some physicians are not satisfied with the program. For cases in the Dependent Children Department, the foster mother is instructed to obtain a doctor when she thinks it necessary and to forward his bill to the District Office for approval and for payment by the Headquarters office.

The Board thus deals with individual physicians. When they assume responsibility for a family or a child they ask the mother or foster mother to name the physician of her choice. The Board then arranges an individual fee schedule with this physician and if he is willing to submit the reports they require, he is designated as the physician for that family or child. This is effective in every county except Morris and Sussex where recently they have a county plan allowing free choice of physician, the plan and fee schedule having been approved by the County Society.

The Board would like to inaugurate a plan in each county, observing the following principles:

1. The plan to be approved by the county society,
2. To provide for free choice of physician.
3. Fee schedule to be arranged with and approved by each county society in accordance with local fees up to $2.00 per office call and $3.00 per house call.
4. An advisory committee from each society to pass upon all controversial matters.

It has been suggested that Medical Service Administration might be of service to them in obtaining the support of the profession, in maintaining adequate standards of care and assisting in the rather complicated (and at present burdensome) administrative details. It has been further suggested that at the start such an arrangement be limited to one part of the state, preferably Essex County. In that county there are 1300 families in the Home Life Department and 1935 children in the Dependent Children Department. In September, 242 persons in the Home Life Department were rendered medical care at a cost of $1850 and the cost of medical care rendered the dependent children was $1015.

It is recommended that M.S.A. continue negotiations with the State Board of Child Welfare with the objective of establishing a plan for the care of dependent children in Essex County in accordance with the "Principles of Cooperation" approved by the House of Delegates in 1947 and patterned after the City of Newark Medical Plan; except that it would include care rendered in physicians' offices and in hospitals.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

It is difficult to state exactly the number of medical care plans formulated by organized medicine, because of the varying status and relationships of these plans; some operated independently, others corporating with lay insurance companies, the majority cooperating with Blue Cross Plans, some approved by the A.M.A., others recognized by Associated Medical Care Plans. Sixty plans have been aproved by the Council on Medical Care of the American Medical Association and of these, fifty-two have been approved for membership in A.M.C.P. Total enrollment of the sixty plans approved by the A.M.A. on June 30, 1947, was 6,700,000 persons, and this has now passed the seven million mark. Some plans still provide only for surgical coverage for services rendered in hospitals, others give a more inclusive service. One plan, (New Hampshire-Vermont) is providing benefits for home and office services in addition to services rendered in hospitals. A few of the plans are of the "indemnity type" only. Some which started as indemnity plans have now changed to "service" plans providing complete payment for services rendered to subscribers with incomes below specified levels. The annual income limitations of these plans (below which the "service" benefits apply) varies from $1500 for a single subscriber to $3000 for family subscribers. The subject of "income limits" is the most controversial problem facing the plans. It is possible that the present income limitations of the plans should be reconsidered for upward revision. They do not altogether conform to prevailing average incomes or the demands of industry and employed groups. This problem is being studied. Any upward readjustment will involve a complete revamping of contracts, changes in subscription rates and schedules of benefits. If these plans are to

meet the needs and demands of industry and the general population, their income limits must reasonably conform to the higher wages paid today and the present cost of living. It is now a question of which plan will first have the courage to make the necessary adjustments.

It is believed that closer cooperation of Blue Cross plans and Medical Care plans at a national level will be to the advantage of all such plans. The Blue Cross Commission and Associated Medical Care Plans are arranging for the organization of a "membership corporation" to represent the two organizations. Major General Paul Hawley will be Director of this new organization.

Our Legislative Committee has emphasized the necessity for more rapid expansion of Medical-Surgical Plan if it is to be effective in combatting universal compulsory sickness insurance. With this opinion we will all agree. Of 63 plans reporting to Associated Medical Care Plans regarding June 1947 enrollments, Medical-Surgical Plan occupied the fourteenth place and was one of seventeen plans with an enrollment of over 100,000 persons. Enrollment in the Plan as of November 30, 1947, was 137,468 persons, involving 779 enrolled groups. This is about 3 per cent of the population of New Jersey. It is anticipated that by January 31, 1948, enrollment will have increased by about 10,000 persons. Chief deterrent to more rapid expansion is the income limitations set forth in our contract governing "service" benefits. New Jersey is a high income industrial state. Wages in industry are now the highest in history with no indication that they will be reduced in the near future. Opinion is expressed by some industrialists that they would not welcome a plan with any income limitation, because it creates discrimination among their employees. One large organization states that it would not be interested in the plan with its present income limitations; that our income limitations would apply only to a small proportion of their clerical force alone, and intimated that they would be interested in a plan adjusted to a $5000 income for married persons. The subject is being considered seriously by the Board to whom it is apparent that some sort of an adjustment must be made to meet the present demands.

Another problem facing Medical-Surgical Plan is reduction in its administrative costs. The earned income of the Plan for the eleven months ending November 30, 1947, was $847,-182 of which $607,343 was paid (or payable) for eligible service rendered by physicians; $144,910, or 17.1 per cent of income was expended for administrative costs; and $94,929, or 11.2 per cent of income was placed in reserve. The total reserve of the plan as of November 30, 1947, was $268,418. The administrative cost of 17 per cent is made up of 12 per cent paid to Hospital Service Plan of New Jersey for their services in connection with distribution of the contract, billing and collecting, general accounting and statistical work performed for us. The other 5 per cent represents the cost of the Medical-Surgical Plan office and printing. Economy in operation can be effected with Hospital Service Plan under an arrangement whereby all claims are processed by Hospital Service Plan personnel without additional expense to Medical-Surgical Plan, with Medical-Surgical Plan maintaining its identity and control of claims and all matters relating to the standards of medical care and patient-physician relationship. Negotiations are now under way to make such an arrangement effective.

The plan has had a successful experience and is on the right road. The solution of its problems must be evolutionary, based upon careful study and experience. With the support of the medical profession its "growing pains" will be solved.

Respectfuly submitted,
Norman M. Scott, M.D.,
Medical Director.

CALLING ALL MEDICAL ARTISTS

To doctors interested in the various arts, an invitation is extended to meet at the Academy of Medicine, 91 Lincoln Park, Newark 5, N. J., Monday, April 12, 1948, at 8:30 p. m., for the purpose of organizing an art association.

The proposed art association will be comprehensive in including all art forms, such as oil and water-color painting, charcoal drawing, sculpture, book plates, engraving, etching, etc.

TRIBUTE TO DR. SCAMMELL

To Dr. Frank G. Scammell whose service to the sick and whose loyalty to his associates made him a well-loved disciple of his profession, members of The Medical Society of New Jersey wish to pay a heartfelt tribute.

A Brilliant Student. He early made his choice of medical profession and thenceforth steered his course carefully and zealously toward his objective, stopping when he felt the need, to acquire new vigor. At the early age of twenty-two he was graduated from Medico-Chirurgical College of Philadelphia and for five years thereafter he practiced in his native city of Trenton. Wishing to equip himself even more thoroughly in his profession, he interrupted his career to do graduate work in gastro-enterology in Philadelphia. This was an unusual procedure, for at that time practitioners generally kept abreast of the times through experience, reading, and attendance at meetings. Again in 1927 he temporarily dropped his practice to seek further training in operative surgery in Europe.

A Successful Consultant. He served long and well as surgeon to Mercer Hospital, Orthopedic Hospital, and the State Hospital.

A Good American. To the welfare and safety of his country he contributed his time and talent. During World War I, he was examining surgeon in the Selective Service System for rural Mercer County and again during World War II he was an official of Selective Service in Trenton.

An Active Public Servant. He felt a special interest in public health and was a pioneer in vaccination. He served both as city physician and as county physician.

A Popular Associate. His unusual organizational talents were highly appreciated by his fellow physicians and were always at their disposal. He was active in the Mercer County Medical Society, the Society of Surgeons of New Jersey, The Medical Society of New Jersey, and the Medical Staff of Mercer Hospital. He served as president of each of these organizations.

The City of Trenton, the State of New Jersey, and the American medical profession have suffered a great loss in the death of this eminent physician.

To his daughter, Mrs. Helen Scammell Walton, whose love for her father, and whose devotion were a great joy to him, we, the members of The Medical Society of New Jersey, extend our deepest sympathy.

THE HARD OF HEARING IN NEW JERSEY

A PLEA FOR BETTER REHABILITATIVE RESOURCES

Sixty thousand New Jersey citizens suffer from hearing loss extensive enough to cause some social or economic handicap. In addition, there are thousands of our school children whose educational progress is impeded by hearing difficulties. What provisions do we have for helping these people?

The otologist tests the hearing, advises a hearing aid. At this point the patient is left to the merchants who sell the various hearing devices. He subjects his auditory nerve to all sorts of unaccustomed sounds. He discards his device in disgust, or he buys one after another in a pathetic and unguided effort to find the ideal instrument. Perhaps he finally does find a satisfactory aid. It will need adjustments and repairs, frequent and sometimes major, which are available only in expensive commercial stores. More than 50 per cent of the victims become so disillusioned that they discard their hearing apparatus.

Satisfactory programs for the hard of hearing are now functioning at Aural Rehabilitation Centers sponsored by the Army (at Walter Reed Hospital), by the Navy (at Philadelphia Naval Hospital) and by the Veterans Administration (at the Aural Rehabilitation Center in New York). At these units are otologists, acoustical engineers, speech correctionists, psychologists and hearing therapists. Here too are devices for evaluating hearing aids and personnel to prepare the patient psychologically and to re-educate him scientifically. In New Jersey, the only place where there is even an approach to this program, is the outpatient division of the State School for the Deaf in Trenton. The New Jersey Rehabilitation Commission uses this facility for persons living in the central part of the state. But in the industrial and more heavily populated districts of New Jersey, we must depend on limited facilities made available to us by agencies across the Hudson or Delaware rivers.

New Jersey citizens are entitled to a mod-

ern rehabilitation program for the hard of hearing. Our rehabilitation measures for such *visible* defects as amputations are widely acclaimed, and in this respect our state has an enviable reputation. But we have little to boast of in our efforts to rehabilitate the *invisible* handicaps—not only the hard of hearing, but other less obvious disabilities such as those occurring in tuberculosis or heart disease.

Sooner or later we will have one or more aural rehabilitation centers in New Jersey. There is no reason why we cannot have these units—equipped with up-to-date devices for testing hearing loss, re-educating the patient, and evaluating hearing aids. The Newark Eye and Ear Infirmary, for instance, if they had the facilities, would be an appropriate site for such a center. Several other excellent locations suggest themselves. The point is that the hard of hearing in our state have a right to supervised service of this sort. It is hoped that the otologists of New Jersey will take the leadership in seeing that these units are established and maintained. If the private practitioner is dilatory in discharging his responsibilities in this field, there are many commercial and lay agencies that will gladly take the program away from the profession. The problem is a challenge to the doctors in general, to the otologists in particular. Let us hope that the challenge will be met.

HENRY A. BRODKIN, M.D., Consultant
New Jersey Rehabilitation Commission.

THE NEW JERSEY PROCTOLOGIC SOCIETY

PRESIDENT'S ADDRESS

Delivered December 18, 1947

I greatly appreciate the honor you have bestowed upon me in electing me your president and being privileged to give the first presidential address to the Society.

For some time previous to the formation of the organization, the proctologic staff of the Newark City Dispensary had been considering the organization of a Society. On the suggestion of Doctors Frank S. Forte, Saul Zager and myself a group of Newark proctologists met on May 14, 1946. A temporary organization was formed and Doctors Forte, Reich and myself were appointed to draw up a constitution and by-laws. At our December meeting, Dr. Saul Zager read a paper entitled "The Relationship of Occupational Strain to Rectal Conditions". The following were elected to membership in the Society: George L. Becker of Paterson, Augustin M. Schultz of Paterson and Jacob L. Mathesheimer of Jersey City.

At our February meeting, Dr. Jacob L. Mathesheimer presented a paper on "The Ambulant Method of Treatment of Pilonial Disease". The following were elected to membership in the Society: M. Browne Holoman and Homer I. Silvers of Atlantic City; William A. Scheffler of Camden, and Urban R. Finnerty of East Orange. It was voted to close our Charter membership list in April 1947. At the next meeting Dr. A. L. Reich presented a paper on "Common Pitfalls in Common Office Procedures". At this session, Lloyd B. Whitman of Woodridge and Richard A. Hopping of Newark were elected to membership.

At our October meeting, Dr. Frank S. Forte spoke on "The Cancer Problem in Proctology". The following were elected to membership in the Society: Wendell J. Burkett of Pitman, James Edson of Paterson, Sidney Rosenblatt of Atlantic City and Benjamin A. Treiber of Trenton. Total membership of the Society is now 24 and nine of us are members of the American Proctologic Society.

At our meeting in December, the speaker of the evening will be Dr. Irving C. Larkey, who will discuss "Pruritis Ani".

We have all had wide contacts and are familiar with the motivations of the individual member and the objectives of the Society "To organize surgeons and physicians of New Jersey who are eligible to membership; for the strengthening of professional bonds and friendly relations among members of the Society. To see maintained in the medical profession high standards in scientific proctologic diagnosis and treatment and the advancement of proctologic knowledge, in all its phases."

We are proud of the progress made during the year. I am impressed with what our Society can do in the years ahead for the improvement in the general health. The support of the membership and its willingness to cooperate in the activities of the Society are very heartening. We must recognize the responsibility that will rest on the members and the

Society. We will dedicate our efforts to maintain the high motives of the Society and give unselfishly in directing the progress of medicine and proctology. I hope that our young men may be able to emphasize the high motivations of the New Jersey Proctologic Society.

Carl H. Wintsch, M.D., Sc.D.,
Retiring President.

ADMISSIONS TO LYONS

Immediate or emergency admission to the Veterans Hospital at Lyons can be authorized only by officials of that institution. Neither the Regional Office nor any of the subordinate VA offices can authorize the *immediate* admission of a patient, because that depends on the availibility of a bed and only the authorities there can say whether space is available.

If you want to determine the possibility of immediate admission call the hospital directly. The number is Millington 7-0180. Since service-connection is often a factor in determining admission priority, it is well to find out, before calling, whether the veteran is receiving compensation payments for a service-connected disability. If the case is elective or the patient can wait for the full processing of his case, the hospitalization unit of the nearest VA office should be called. Here are the phone numbers:

Newark: MArket 3-6800 (counties of Essex, Middlesex, Morris, Somerset, Sussex, Union, Warren and Passaic).

Union City: Union 7-3307 (counties of Bergen and Hudson).

Trenton: Trenton 4-7191 (counties of Burlington, Hunterdon, Mercer, Monmouth and Ocean).

Camden: Camden 4-8757 (counties of Atlantic, Camden, Cape May, Cumberland, Gloucester and Salem).

Lyons: Millington 7-0180 (all emergency admissions).

OBITUARIES

DR. J. WILLIS DEMAREST

Dr. J. Willis Demarest, city and school physician of Hackensack, died of heart trouble on November 18, 1947, at the age of 48. A specialist in children's diseases, he was assistant director of the pediatric department of the Hackensack Hospital.

DR. FRANK R. HUGHES

Dr. Frank R. Hughes, 68, well known Cape May physician, died on February 5 in the Hahnemann Hospital, Philadelphia.

A native of Cold Spring, Dr. Hughes taught school before entering Hahnemann Medical College. He received his medical degree in 1906, and upon the completion of his internship in Hahnemann Hospital in 1907, he returned to Cape May where he practiced general medicine and surgery until 1945, when he was seriously injured in an automobile accident from which he never fully recovered.

Dr. Hughes was coroner of Cape May County from 1922 to 1925, served as medical examiner for the Cape May schools for several years and was associated with the Boards of Health of Lower Township, West Cape May and Cape May for many years. In 1945 he was awarded an honorary degree of Doctor of Science by his alma mater. He was medical officer in charge of the U. S. Public Health Service Relief Station in Cape May from 1926 until 1945, participating in many flights with the U. S. Coast Guard during the pioneering days of its air-sea rescue service, including rescue work following the Akron and Morro Castle disasters. During World War I he served on the Cape May County Advisory Board and was an examining physician for Selective Service during World War II.

DR. CALDWELL MORRISON

Dr. Caldwell Morrison of South Orange, who retired in 1943 after 50 years as a general practitioner, died on December 24, 1947, in Fair Oaks Sanatorium, Summit, at the age of 81.

Dr. Morrison first practiced medicine in Summit, but moved his office to Newark in 1904. He received his medical degree in 1889 from New York Homeopathic College. He was an honorary member of the Essex County Medical Society.

DR. HOWARD H. NYE

Paterson lost one of its leading obstetricians on December 28, 1947, with the death of Dr. Howard H. Nye. Dr. Nye was born in Lima, Ohio, in 1890, and received his medical degree from Jefferson Medical College in 1921. After serving internship at the Paterson General Hospital, he practiced in Paterson and joined the General Hospital staff. In 1928 he was appointed chief obstetrician, a position he held at the time of his death.

DR. HORACE N. PARKER

Dr. Horace N. Parker, Trenton, died on January 4, 1948, at the age of 65, following a short illness.

Dr. Parker was graduated from the Medical School of the University of Pennsylvania in 1907. He had served as a clinician with the City of Trenton Health Department since 1919.

THE BULLETIN BOARD

REORGANIZATION OF LOCAL HEALTH UNITS

By action of the Board of Trustees, The Medical Society of New Jersey is on record as favoring the principle of S-148, a bill introduced in Trenton by Senator Arthur W. Lewis of Burlington County, which would permit the 930,000 people living in the 360 municipalities of the 14 smaller counties of New Jersey to reorganize their local health departments into county or part-county units.

Proponents of this bill point out that it supplements the provisions of the law passed last year, providing for modernization of the state health department. S-148 will make it permissible for local health departments in the counties affected to band together in units of 25,000 population or more, setting up county or part-county health departments with full-time personnel.

Today only thirteen states in the union have smaller proportions of their total population enjoying the benefit of local full-time public health services.

The bill scrupulously observes the principle of home rule; but, as a practical means of encouraging the voluntary grouping together of local health units, the state health department would be authorized to subsidize approved county or part-county health departments up to 50 per cent of their total budgets, provided that this subsidy does not exceed $1 per capita per year per district.

The bill stipulates that cities of more than 25,000 population located in counties where a county health unit is being formed, may join the county unit only if their municipal authorities so request and if the proposal is approved by the county freeholders. Communities of less than 25,000 population may, if they prefer, keep their own boards of health and do their own public health work as long as this work meets the minimum standards of the state health department. Even those communities included within the county health district may also keep their own boards of health and employ their own personnel, but entirely at their own expense.

It is expected, however, that where a county health department is established, most of the boards of health of the boroughs and small cities will be discontinued, and township committees now serving as local boards of health will give up that part of their duties.

The net cost of modern full-time health service under this program is expected to be not greatly in excess of the total amounts now spent by individual communities for the services they now receive.

Provision is made for re-employment of public health nurses, health officers, and inspectors who have state health department licenses by the county or part-county units that may replace their local health departments.

This bill is modeled after plans that have proved successful in other states. Since its original introduction last year, the bill has been considerably improved in the light of suggestions made at that time. It is actively sponsored by the New Jersey Health and Sanitary Association and the sponsors hope that it will receive the support of all agencies, physicians and laymen interested in improving public health work in New Jersey.

In an editorial in the *Journal A.M.A.* for February 14, 1948, the suggestion is made that:

> "Members of the medical profession may provide leadership for this movement in various ways . . . Possibly some local health officers now providing good service on a part time basis will be slow to see the need for the revolutionary shift to the full time basis. Local boards of supervisors, town councils and boards of aldermen may hesitate to pool their resources with contiguous units and thus give up some of their local autonomy. Local communities may wonder if it is really necessary to look beyond their present staff of public health workers and bring in specialists trained in public health administrative procedure. The fact that prompt realization of the complete plan may require some years is no reason for failing to begin. The medical profession must assume active leadership locally in this reformation of the local public health administration of the country."

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"MEMBERSHIP" AND "FELLOWSHIP" IN THE AMERICAN MEDICAL ASSOCIATION

Many members are apparently not familiar with the distinction between membership in the American Medical Association and the more important category of "fellowship". The following information, therefore, may be of interest in view of the forthcoming annual sessions of the American Medical Association in Chicago this June. Only Fellows of the A.M.A. are permitted to attend the scientific meeting and to view the scientific exhibits at the annual sessions.

Here are the official definitions:

Every *member* in good standing in the constituent medical association of the state in which he is engaged in practice whose name is officially reported to the secretary of the American Medical Association for enrollment becomes automatically a *Member* of the American Medical Association and is not called on, as such, to pay any dues or to contribute financially to the Association.

Members of the American Medical Association are eligible to apply for Fellowship.

To qualify as a *Fellow,* a member in good standing is required to make formal application for Fellowship, to pay Fellowship dues and to subscribe to THE JOURNAL. Applications must be approved by the Judicial Council.

Fellowship dues and subscription to THE JOURNAL are both included in the one annual payment of $12, which is the cost of THE JOURNAL to subscribers who are not fellows.

Members of constituent state medical associations pay dues to those bodies, but as "members" they pay nothing to the American Medical Association. Fellows pay dues and subscription to THE JOURNAL in the sum of $12 a year, which has nothing to do with county or state dues.

According to an amendment to the By-Laws of the American Medical Association, no physician may be officially recorded as a member of the American Medical Association except on the basis of membership in *one* constituent state medical association. That one must be the Society of the state in which the physician maintains legal residence or engages in the practice of medicine.

Each Fellow receives a Fellowship Card from the Association annually as payment of his dues is recorded. This card is presented for admission to the Annual Meetings of the Association.

Physicians who are eligible for Fellowship should make formal application immediately so that they may attend the Chicago Session.

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HOSPITAL DEFICITS

Mounting deficits of the voluntary hospitals in New Jersey are a matter of concern to the physician no less than to the hospital administrator and trustee, whose legal responsibility it is to see that they are met. For it is a truism that the fate of the voluntary medical system in the United States is inextricably tied to the fate of the voluntary hospital system.

The Medical Society of New Jersey has lent the full weight of its influence to supplement the efforts of the New Jersey Hospital Association in awakening the public to the plight of the voluntary hospitals. We have joined the hospitals in a continuing effort to persuade municipal and county authorities to increase their *per diem allowances* to hospitals for the care of patients who are public charges.

The major part of the deficit of most of the voluntary hospitals is represented by the difference between the actual cost of the hospital care of public charges and the insufficient *per diem* allowance received from public authorities on behalf of such patients.

That we are not alone in facing this problem and in estimating its seriousness is shown by a vigorous editorial statement that appeared recently in the *New York State Journal of Medicine.* Referring to the situation in New York City, the New York State editor declared in part:

"If this city, like many another, can't take care of its own ailing, let it say so. But do not let it keep up the pretense that it is doing so when actually it is asking private charity to shoulder half its burden and arrogating the credit to itself.

"Do not let the average citizen be gulled into thinking that the city or state is taking care of him when it is not. Not when private charity is being bled white.

"If there ever was a matter which should become one for public discussion, this is it. If our social system is going to change, very well. If the fountains of private charity are to be exhausted, perhaps that is inevitable. But we can at least put our cards on the table.

"We cannot allow our system of voluntary hospitals and our long and honorable tradition of the best care for the sick poor by the best men of the medical profession, unremunerated, to be dragged down by the inadequacy of any system of socialized care that hasn't worked well, doesn't work well, and probably won't work well.

"Are we to be forced to abandon a voluntary hospital system which is one of the proudest evidences we can present of the sense of obligation of our well-to-do people and be constrained to substitute a municipal or state system of socialized care which will then be pointed out as one of the most recent and most glaring evidences of the failure of private enterprise?"

In asking public authorities, and other agencies responsible for the care of certain hospital patients, to pay the full cost of services rendered their clients, it should be emphasized that we are *not* proposing direct public subsidy. We are not asking the government—federal, state or local—to underwrite deficits as such. In fact, that is what we seek to avoid. For, apart from the fact that deficit subsidies are unsound financial policy, they lead directly to public control and political management.

JAMES E. BRYAN,
Executive Officer.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

PUBLIC HEALTH NURSING WEEK
April 11-17, 1948

Professional and civic groups are now planning local observances of Public Health Nursing Week, scheduled this year for April 11 to 17.

The basic purpose of this movement is to help more people to understand better what public health nursing services can do to make lives healthier and happier, to help more young women to realize the value of public health nursing as a career and to enlist greater cooperation on a community level for the provision and use of public health nursing services.

Physicians can take an active part in local public health nursing week observances both in the planning and in participation.

Plans are now being made and the following suggestions may prove helpful:

1. Organize a committee in your community to sponsor the "Week". Both nurse and non-nurse members of the official and non-official agencies should be included, as well as the Health Officer, representatives of the press, schools, churches, business organizations, labor, board members of Visiting Nurse Associations, and physicians in the area.

2. Organize a Speakers Group. Invite friends of public health nursing to speak at local meetings.

3. Ask your mayor to sign a proclamation.

4. Hold a public meeting.

5. Use the local or nearby radio stations.

6. Conduct a public opinion poll.

7. If you have a hospital in your community, emphasize student nurse activities. Since recruits for public health nursing are drawn from among younger nurses, schools of nursing will want to participate in plans for the "Week".

8. Plan Exhibits. Window displays in local stores—Public Health Nursing posters—and other types of exhibits are good publicity.

9. Get complete newspaper coverage. Local editors are eager to assist with special community programs. Prepare a list of facts about local public health nursing activities and present them to the press. Get local people to prepare articles for publication. Local journals and magazines are nearly always willing to cooperate too.

10. Ask your schools to plan programs of interest to the children. Parent-Teacher Associations may wish to plan their own schedule of events.

To obtain more help in planning your local "Public Health Nursing Week" you may write to the following organizations for further suggestions:

(A) Chairman of Public Health Nursing Week Committee of the New Jersey State Organization of Public Health Nursing—Mrs. A. Howard Saxe, 54 Early Street, Morristown, New Jersey. (Free kit for community planning will be supplied.)

(B) National Organization for Public Health Nursing—1790 Broadway, New York 19, New York.
(Special Publicity kits to aid your local committee can be purchased for a dollar each.)

WHOOPING COUGH BOOSTER SHOTS

The principle of giving booster shots of whooping cough vaccine to pre-school children has been endorsed by the Public Health Committee and the Board of Trustees of The Medical Society of New Jersey. Complete plans for a whooping cough control program are given in *The Control of Whooping Cough in New Jersey,* a manual available to physicians, school administrators, health officials, public health nurses and others concerned with the control of whooping cough. Also available in quantity and for community and school use is a pamphlet for parents *Two Steps to Protect Your Child from Whooping Cough,* and a three-color poster for health departments, baby stations, schools and other uses. All are available without charge from the Health Education Division, State Department of Health, Trenton 7, New Jersey.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

The *Atlantic County Medical Society* held its regular monthly meeting at the Traymore Hotel, on February 13, 1948. The president, Dr. Clarence Whims, presided. The speaker of the evening was Dr. H. L. Bockus, professor of gastro-enterology in the Graduate Hospital of the University of Pennsylvania. His subject was *Recent Advances in the Diagnosis and Treatment of Pancreatic Disease.*

Dr. Bockus divided pancreatic disease into two types, namely: 1. Acute necrosis of the pancreas. 2. Edema of the pancreas.

He stressed differential diagnosis because pancreatic disease simulates many other conditions such as ruptured peptic ulcer, coronary accidents. intestinal obstruction, mesenteric thrombosis, etc. The diagnosis is not easy to make. Blood enzyme determinations are essential to arrive at a diagnosis.

Paramount among his warnings was the advice not to operate immediately. It is wise to wait for complications before operation is considered. Medical treatment is aimed at the prevention of pancreatic juice stimulation. Among the recommendations made are: 1. Gastric intubation to remove gastric juice. 2. Keep stomach alkalinized. 3. Atropine every four hours. 4. Parenteral fluids. 5. Sedation. 6. Prevent diabetes. Surgical interference only for hemorrhage, peritonitis, or suppuration.

Edema of the pancreas is always associated with gall-bladder disease. Blood enzyme determinations are very useful in diagnosis.

Following any pancreatic disease there is residual damage; these patients should be instructed not to drink alcohol nor eat fatty foods.

Cancer of the pancreas is determined by the presence of weight loss, pain, age of the patient and elevation of the blood lipase.

Dr. Bockus concluded his very instructive paper with lantern slides of cancer of the pancreas stressing chiefly x-ray evidence in making a diagnosis of malignancy. A very lively discussion followed.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* held at Bergen Pines Hospital, Oradell, on the evening of January 13, 1948, was called to order by the president, Dr. Rudolph C. Schretzmann, at 9:25 p. m.

The minutes of the Executive Committee of December 16, 1947, were approved as published in the Bulletin.

On recommendation of the membership committee, the following applicants were elected to full membership: Drs. Harry L. Harwood, Palisades Park; Anthony J. Persico, Harrington Park; Reginald F. Seidel, Englewood; S. Harvey Sklar, Cliffside Park; A. M. Susinno, Palisades Park; Hildegard S. Vargish, River Edge, and Jacob J. Vargish, River Edge; Dr. Robert B. Gorman, Oradell, by transfer from Lake County, Indiana; Dr. Herbert S. Sharlin, Hackensack, by transfer from Essex County, N. J., and Dr. Evelyne L. Sabey, Palisade. Drs. Sadie Blackman, Westwood; Evelyn E. Dresner, Ridgefield Park; Matthew Feldman, Teaneck; Vito J. Kemzis, Closter; Peter Minck, Jr., Saddle River Borough; Howard J. Rosenbauer, Hackensack; Francis Rosner, Maywood, and Alexander L. Szot, Wallington, were elected to associate membership.

The following doctors, introduced by Dr. George M. Knowles discussed *Antibiotics — Present Day Concepts of their Use:* Dr. Winton H. Johnson, Hackensack Hospital; Dr. John E. Dietrick, director, Second (Cornell) Medical Division, Bellevue Hospital, associate professor of medicine, Cornell University Medical School; Dr. Charles D. Roberts, Englewood Hospital; Dr. Edward V. Sexton, Holy Name Hospital; Dr. Stewart F. Alexander, Hackensack Hospital, assistant in medicine, College of Physicians and Surgeons, clinical assistant in medicine, New York University.

Dr. Dietrick had been scheduled to give a short talk on *Summary of the General Usefulness of Penicillin and Streptomycin,* but yielded his time because of the lateness of the hour, to hear Dr. James F. Norton, who was asked to attend the meeting and to acquaint the members with some important facts. Dr. Norton said that every member should know what benefits come to every component Society from the State Society and pointed out that each County Society contributes to the state organization by way of an assessment. He also stated that a few members may feel that the dues are too high, but the State Society has a very active personnel, working twenty-four hours a day, and that it is necessary to employ Executive Officers at a goodly salary; also there are many activities which cost money. The State Society has a budget of about $100,000 a year. Dr. Norton asked that contributions to the State Society be continued, and that confidence must be placed in the men who are conducting the affairs of the state organization. He also suggested that the County Societies be careful in the selection of their Nominating Delegates to the State Society, and asked that some thought be given to the representatives sent to the Welfare Committee. He also urged that the members very seriously look upon the responsibilities they have, because they represent a group of intelligent people in the discharge of the affairs of organized medicine.

The meeting was adjourned at 11:15 p. m.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at the Riverton Country Club, on February 12, 1948. The meeting was called to order by Dr. Warren Rodman, president of the Society.

As is the custom the scientific portion of the meeting was placed ahead of the regular business meeting. The guest speaker of the evening, DR. HAROLD D. BARNSHAW of Camden was introduced by Dr. Dean LeFavor and spoke on the subject "Problems of Ophthalmology in General Practice". The speaker began his talk by describing the conditions found in new born babies and in infancy. Penicillin is now beginning to supplant silver nitrate in ophthalmia neonatorum. The lacrimation of a baby's eye is due to a blocked duct which has to be treated. Strabismus in a child should be seen by an ophthalmologist as soon as possible so that the condition may be observed and the eye grounds examined at regular intervals to discover whether or not any atrophy is taking place. To correct this condition an operation is usually necessary. Dr. Barnshaw next described the procedure for removing foreign bodies and also the correct technic for finding corneal injuries. Glaucoma and iritis are usually first seen by the general practitioner who should make his diagnosis early so the proper treatment may be instituted. The ophthalmologist is often called upon in cases of hypertension and eclampsia to examine the eye grounds and to give his opinion as to whether or not in the case of the former an operation would alleviate the patient and in the latter if the patient can be carried to term. In regard to corneal transplants the cornea remains clear resulting in a useful eye in about thirty per cent of operations. The replacement of detached retinas is now fairly successful. The treatment of hordeola has not changed to any great extent in the last few years. Dr. Barnshaw commented on the use of contact lenses. If properly fitted they will not hurt the eye but are often uncomfortable at first. As a result the patient will not persevere until he has become accustomed to them which is the reason many people are dissatisfied with them. The advent of sulfanilamide and penicillin has been a great benefit to the ophthalmologist as well as to the rest of the medical profession. Drs. Harry Landis, Dean LeFavor and Joseph Kuder were the leaders in the discussion which followed Dr. Barnshaw's talk. The members of the Society learned many practical things to do in the treatment of conditions which were described by the speaker.

The Red Cross in conjunction with the County Society is planning to compile a list of blood donors in the county which might be used in the case of an emergency. It was made clear that this was to be an emergency list only and that patients in the hospital who need transfusions will endeavor to obtain necessary donors in the same manner which is in use at the present time.

CUMBERLAND COUNTY

E. C. Greene, M.D., Reporter

Under the chairmanship of DR. SIDNEY L. SIEGEL, its president, the *Cumberland County Medical Society* held its regular meeting at the White Sparrow Inn, Delsea Drive and Park Avenue, Vineland, February 10, 1948.

The newly elected members were given a cordial welcome.

Dr. Charles Cunningham reported on the plans for the mid-winter social event to be held at the Hotel Cumberland in Bridgeton, March 17, 1948. He promised a pleasant evening for the members' wives and guests.

Dr. Charles Butcher, whose grandfather, Dr. Joseph Butcher, was one of the charter members of the Cumberland County Society, suggested that since 1948 marked the 100th anniversary of the founding of the society, this occasion might be used to celebrate the centennial. He explained that the society had been organized 19 years before but during the subsequent 18 years had become inactive so that 1948 marked the 100th year the society had been in continuous operation.

Dr. Charles Cunningham opened the scientific program by introducing DR. J. GERSHON-COHEN, roentgenologist at Newcomb and Millville Hospitals and former Commander, U. S. Navy, whose lecture *The Atom: Hail or Hell* held every member's rapt attention for almost an hour. His dramatic review of the outstanding events in the history of physics leading up to a climax of the present atomic age met with an enthusiastic response.

GLOUCESTER COUNTY

L. K. Collins, M.D., Reporter

DR. JOSEPH F. HUGHES, president, was in the chair as the *Gloucester County Medical Society* met at the Woodbury County Club, January 15, 1948, at 9 p. m. DR. WENDELL J. BURKETT, chairman of the legislative committee, gave a detailed and comprehensive report. Dr. Burkett mentioned that the nine professional licensing boards in New Jersey would probably come under the Department of State in the new constitutional setup. He also discussed the situation in Washington in reference to pending legislation.

Dr. Hughes then introduced MR. JAMES E. BRYAN, the new executive officer of The Medical Society of New Jersey. Mr. Bryan stated that his primary duties in the State Office were public relations with the county societies, the individual physicians, and the public at large. He brought out the point that in the past the practicing physician was more often heard by the public when opposing certain measures, and did not bother to express himself in support of many worthwhile activities. Rather than just opposing socialized medicine, the doctor should explain and support his views, and foster the development of voluntary prepayment plans of medical insurance, which is the real sensible answer to the problems of medical economics.

LOWELL A. ERF, M.D., of the Hematology Department of the Jefferson Medical College then addressed the members of the society on "Newer Methods of Treatment of the Common Blood Diseases". Dr. Erf discussed the remarkable results achieved from splenectomy in hemolytic jaundice, and the possibilities of recurrence if an accessory spleen were not removed. He described the results with radioactive phosphorus and urinary extracts in the treatment of leukemia. A coagulant globulin obtained from the Red Cross in limited quantities is very useful in hemophilia. Dr. Erf pointed out the limitations of folic acid about which

much has been written in the lay press. The question and answer period was concluded with a learned description of the complexities of the Rh factor.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held a regular monthly meeting on January 6, 1948, at the Jersey City Masonic Club, with Dr. Driscoll in the chair.

Dr. Pasquale A. Statile of Jersey City was elected to membership.

A scientific session on *Tuberculosis* was arranged by Dr. A. E. Jaffin, Chief of Hudson County Diagnostic Chest Clinics and Chairman of Tuberculosis Advisory Committee of The Medical Society of New Jersey. Dr. Jaffin was unable to be present because of illness.

Guest speaker of the evening was Dr. Edgar M. Medlar, associate professor of pathology, College of Physicians and Surgeons, Columbia University; and director of research, Hegeman Memorial Fund. Dr. Medlar asserted that Bacillus tuberculosis is rampant at the present time to a much greater degree than is generally believed, notwithstanding statistical reports that seem to indicate otherwise. He based his assertions on a study of tuberculosis which he made in connection with Medical Examiner cases of sudden death in New York City, an amazing percentage of which disclosed open tuberculosis cavities on examination. Dr. Medlar emphasized the fact that when a tuberculous process becomes manifest by any present method, including x-ray, it is already a well established lesion.

A paper entitled *The Problem of Tuberculosis as the Clinician Can Meet It,* prepared by Dr. Jaffin, was read by Dr. Hyman Borshaw. Facilities for the detection of tuberculosis in the diagnostic chest clinics of the county were described, and physicians were urged to avail themselves of these facilities in instances where the patient cannot afford the services of private physicians.

Dr. Pollak, Dr. Herradora and Dr. Perlberg joined Dr. Medlar in a general discussion of tuberculosis from the clinical and roentgenological standpoints.

Mr. Nelson R. Kraemer, Executive Secretary of the Hudson County Tuberculosis League, a guest at this meeting, spoke briefly on the objects and ideals of the Tuberculosis League.

Adjournment followed a rising vote of sincere appreciation to Dr. Medlar. A collation was served.

MIDDLESEX COUNTY

Anthony J. Pellicane, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on Wednesday, January 21, 1948, at the Roosevelt Hospital, Metuchen.

Dr. Edward F. Klein, the president, called the meeting to order at 9:10 p. m., and introduced the speaker of the evening Dr. Alexander Brunschwig, attending surgeon at Memorial Hospital, New York City, and professor of clinical surgery at Cornell University Medical School. He spoke on "Extensive Surgery in the Treatment of Advanced Abdominal Carcinomas" and supplemented his paper by citing numerous case histories and presenting lantern slide illustrations. Patients with isolated metastatic growths who, a few short years ago, were considered to have a hopeless prognosis, were now receiving his surgery with a definite percentage showing a 58-month cure and the amelioration of symptoms for several years of another large group. Discussion of this paper from the floor followed, and Dr. Brunschwig was good enough to expound more fully on his subject by answering the many questions regarding the operative procedures and the pre- and post-operative management of his patients. On motion of the Society, a rising vote of thanks was offered to Dr. Brunschwig for his most interesting and valuable presentation.

The business session was then opened. The reading of the minutes of the previous meeting, the Annual Banquet and election of officers meeting, was dispensed with. On recommendation of the Ethics Committee, Drs. Benjamin D. Jacobson and William R. Finnegan were elected to regular active membership from their previous associate membership status.

Dr. Benjamin Slobodien of the Central Blood and Plasma Bank Committee, Dr. M. F. Urbanski of the Cancer Control Committee, Dr. F. M. Clarke of the Post-Graduate Education Committee, and Dr. Carlyle Morris of the Committee for the Establishment of a Medical School in Rutgers University, reported on their progress and plans.

Dr. Florentine M. Hoffman read the first ten sections of the proposed revision of the Code of Ethics. Several items provoked a great deal of discussion, and it was suggested that any member who desired to amend the controversial portions, should submit his recommendation in writing to the Committee for the Revision of the Code of Ethics before the next meeting. Consideration of further changes in the proposed Code was then postponed until the next meeting.

Dr. F. M. Clarke moved that a letter of censure be forwarded to Dr. Leo Davidoff of New York, to the Medical Society of New York State, to his County Medical Society, and to the Dean of Columbia University School of Medicine, regarding his published approval of an article which appeared in the *Readers Digest* which held up the surgeons and the entire medical profession to scorn, and accused the majority of medical men, by innuendo, of unethical conduct. Motion was seconded and approved.

The meeting was adjourned at 11 p. m., after which a collation was served in the hospital dining room.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

Dr. Aldrich C. Crowe, Chairman of the Board of Trustees of The Medical Society of New Jersey, was the first speaker at the regular monthly meeting of the *Monmouth County Medical Society* held in the auditorium of the Monmouth Memorial Hospital, Long Branch on January 28, 1948. Dr. Crowe presented matters of interest regarding the activities of the State Society. Emphasis this year will be placed on the following groups: cancer con-

trol, veteran's medical care, venereal disease control, child health, industrial medicine, voluntary prepaid medical plans and possible future medical legislation. Improvement of public relations will also be an aim of this year's work.

The principal speaker of the evening, DR. JOHN R. NEEFE, was introduced by Dr. Samuel Edelson. Dr. Neefe is an instructor of medicine at the University of Pennsylvania and was formerly consultant on epidemic diseases to the Secretary of War. Dr. Neefe's paper *Viral Hepatitis* was a comprehensive and vital coverage of the subject. Viral hepatitis is divided into two groups: infectious hepatitis and homogenous serum hepatitis. That these two are different was demonstrated by numerous facts concerning onset, symptoms, immunity and infectious agent. Dr. Neefe emphasized the possible inoculation of hepatitis through the use of plasma, blood, syringes and needles. Human homoglobulin is an effective preventive against the infectious hepatitis but not against homogenous serum hepatitis. The role of the liver function tests was presented. The paper closed with the presentation of the now accepted treatment of viral hepatitis.

Dr. Altschul opened the discussion which followed. Questions were received from the floor. Dr. Neefe closed the scientific meeting by answering the numerous questions.

Dr. Albright, president, opened the business meeting. A letter of thanks was received for the Christmas gift in memory of Dr. Mason from Mrs. Mason. Final reading of the proposed amendment concerning courtesy membership was voted upon and accepted.

DR. SAMUEL ADLER of Red Bank, DR. FREDERICK STELLER of Spring Lake, DR. JACOB RUBIN of Asbury Park, DR. J. PATTERSON COOPER of Matawan and DR. JOHN PAINE of Asbury Park, were elected to full membership. DR. JOHN HILL of Allenhurst and DR. EDWIN STEWART of Fair Haven were elected to honorary membership.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held Tuesday evening, January 20, 1948, at 9:00 p. m., in the Freeholders' Meeting Room, Administration Building, Paterson.

At the business session preceding the scientific portion of the meeting the following were elected to membership: Active membership—DRS. JOSEPH F. ZIGARELLI, NADHIM E. MEER, ALVIN H. KRAKOWER, ANTHONY J. SANTORO, of Paterson; PHILIP SNELL of Passaic; MICHAEL J. RESSETER of Clifton, and GERARD J. ALONZO of Lyndhurst; associate membership—DRS. FRANK SCILLIERI, JOHN A. INSOLERA, PAUL SZAFIR, MORTON KULICK of Paterson; ANDREW D. KERR, JR. of Clifton, and ROBERT CANAAN of Fairlawn.

The following Resolutions were adopted:

WALTER LIVINGSTON DUNNING, M.D.

Dr. Walter Livingston Dunning, aged 71, of 533 River Street, Paterson, New Jersey, left this mortal life November 29, 1947.

Doctor Dunning was born in Paterson and received his elementary education in our local schools and his medical training at the Long Island College of Medicine, being graduated in 1898. He was licensed to practice in New Jersey in the same year.

He was elected to membership in the Passaic County Medical Society in 1905, and was granted an Emeritus Membership after forty years. He became a member of The Medical Society of New Jersey and the American Medical Association.

Doctor Dunning settled in the Riverside section of Paterson where he practiced his profession faithfully, honorably and with sympathetic understanding for almost fifty years. He was the family doctor to innumerable patients serving them unselfishly throughout their lives. He served as physician in our local school system for thirty years.

WHEREAS: The Almighty God in His Infinite wisdom, has deemed it best to take from our midst, Walter Livingston Dunning, devoted physician, faithful friend and respected citizen and

WHEREAS: The Officers and Members of the Passaic County Medical Society feel that the loss of so fine a resident and colleague will be keenly felt by all his friends and former patients.

WHEREAS: His departure marks a severe loss to our community and to those whom he associated with in his profession and private life, be it therefore—

RESOLVED: That the Passaic County Medical Society will long remember Doctor Dunning for his loyalty to his patients, his colleagues and friends.

BE IT FURTHER RESOLVED: That this Resolution be inscribed in full upon the minutes of this meeting and a copy be presented to his family.

ISRAEL FEIGENOFF, M.D.

Doctor Israel Feigenoff, aged seventy, of Paterson, New Jersey, died October 5, 1947.

Dr. Feigenoff was born in Russia and came to this country as a youth. He had received his pre-medical education in Europe and after learning the language, entered Long Island Medical College from which he was graduated in 1905.

He began the practice of medicine in Paterson and became associated with the Barnert Hospital, as one of its founders in 1908. Six years later when the present hospital building was built he was appointed Attending Pediatrician, a position which he held until his appointment as Emeritus Consultant in 1945.

Dr. Feigenoff was a member of the Passaic County Medical Society, a member of The Medical Society of New Jersey and a Fellow of the American Medical Association.

He served our community as physician to the Paterson and other county school institutions. During both wars, he served loyally as examining physician to the selective service and draft boards.

The following Resolutions are offered:

Whereas: Israel Feigenoff, devoted physician, kindly friend and beloved colleague, has been taken from our midst and

Whereas: the officers and members of the Passaic County Medical Society mourn the loss of so fine a citizen and conscientious servant, whose homely philosophy and sincere friendliness will be missed by all who knew him and

Whereas: his departure is a severe loss to our community and to all who were associated with him professionaly and in his private life, be it therefore

Resolved: that the Passaic County Medical Society will long remember Dr. Feigenoff for his loyalty and interest in the welfare of the Society for over thirty-five years.

Be It Further Resolved: That this Resolution be inscribed in full upon the minutes of this meeting and that a copy be forwarded to the bereaved widow and her family.

THOMAS MacNEESE GLASGOW, M.D.

Whereas: in the death of Doctor Thomas MacNeese Glasgow, the Passaic County Medical Society has sustained an irreparable loss and the community at large a useful and outstanding citizen and

Whereas: for a great many years, Dr. Glasgrow has been a highly respected member of the Passaic County Medical Society, to which he has given unselfishly of his time, his skill and his energy

Be It Therefore Resolved: that in his passing we have lost a member who was sincerely esteemed by his fellow physicians for his faithfulness, loyalty and unfailing devotion to the highest principles and practices of the medical profession and

Be It Further Resolved: that these Resolutions be spread in full upon the minutes of the Passaic County Medical Society meeting and that a copy be presented to his family.

The scientific session was opened by Dr. J. Allen Yager, vice-president, who presided in the absence of Dr. De Yoe, the president. Dr. Yager introduced the speaker of the evening, Maurice Lenz, M.D., professor of clinical radiology, Columbia University, consultant radiotherapist to Presbyterian Hospital, and president-elect of the American Radium Society who spoke on the "Radiocurability of Cancer" and illustrated his talk with lantern slides. Dr. Lenz's address was exceptionally educational, and was followed by much interested discussion.

SALEM COUNTY

D. G. Neander, M.D., Reporter

In the absence of the president, Dr. C. F. Fleming, the vice-president, called to order the regular meeting of the *Salem County Medical Society*, held on January 16, 1948, at the DuPont Penns Grove Club. Through the courtesy of the Abbott Laboratories, an instructive film was shown on the use of sodium pentothal. The film illustrated the mode of action of pentothal, its indications and contraindications, and the proper technic of administration. After a short discussion of the subject, a rising vote of thanks was given the Abbott representatives for their kindness in presenting the film.

Following the scientific part of the meeting, the business session was opened. Dr. E. E. Evans led the discussion concerning the establishment of a blood bank pool in Salem County. This pool would consist of about 600 donors on a voluntary basis. The organization of the bank would be done by the American Red Cross, but would be sponsored by the local Medical Society. Under the plan, a list of donors would be available at the Salem County Memorial Hospital and at Red Cross headquarters.

A motion was made and passed that the Society sponsor such a blood bank.

The minutes of the last meeting were approved as read.

Several letters were read concerning legislative efforts and the problem of socialized medicine. Members were urged to become more active in dealing with this problem.

The meeting was then adjourned, and the members and guests gathered in the club dining room for dinner.

WARREN COUNTY

Joseph C. Humbert, M.D., Reporter

A joint meeting of the *Warren County Medical Society* and its Woman's Auxiliary was held at Harkers Hollow Country Club at 11 a. m., January 20, 1948. President-elect Dr. Frank Bartolini called the meeting to order, turning the chair over to the president, Dr. Walter Boquist, on his arrival.

A panel discussion of the Four-Point School Health Program followed, with remarks by Mr. James E. Bryan, in charge of public relations for the State Medical Society; Mrs. Lodovico Mancusi-Ungaro, president of the State Woman's Auxiliary, and Mr. Will Atwood, superintendent of the Warren County School System. Mr. Atwood expressed himself as heartily in favor of the plan, but, analyzing it in detail, pointed out that many legal and financial obstacles had to be overcome before the plan could become effective.

Mr. Bryan then discussed the public relations of the State Medical Society, which he said were deservedly good, and told what the Society was doing in using the radio and press in health education.

Dr. Robert Buck, an optometrist, associated with the Hackettstown Red Cross blood donor program, asked the Society to approve the program. The Society had previously withheld approval because of lack of information about the project's laboratory facilities, but on this occasion voted to approve it.

The joint meeting then adjourned and the regular Warren County Medical Society meeting was held. A request from Dr. Frank S. Gordon to be admitted to affiliate membership was tabled until more information could be obtained. The resignation of Dr. Eugene E. Cioffi was accepted. Amendments to the by-laws that in effect would call for bi-monthly evening meetings, were unanimously adopted. The Society formally approved a proposal by Dr. Paul Drake that a county school physicians association be organized.

The society then adjourned to the dining room to have dinner with the Woman's Auxillary.

WOMAN'S AUXILIARY

AN INVITATION TO THE ANNUAL MEETING

Oh forget your coughs and sneezes
And absorb the cooling breezes
That vacations at the seashore always bring
Take a leave from daily duties
And enjoy the vernal beauties
Of Atlantic City's boardwalk in the spring
There'll be food and recreation
(It's an Allman preparation)
We'll do our work—but leave some time for play
So make yourself all pretty
And come to Atlantic City
April 27th *is* the starting day
Many old friends you'll be greeting
As you take part in the meeting
Or enjoy the dancing on the final night
And in spite of these distractions
Hear reports of all our actions
And help Inez Walker start her year a'right.

Frances Mancusi-Ungaro,
President.

AUXILIARY REPORTS

Atlantic County

Mrs. Matthew Molitch,
Chairman, Press and Publicity

A panel discussion on "Mental Hygiene in Relation to Community Life" with the emphasis on the need for a mental hygiene clinic in Atlantic City was held by a group of experts in the field of psychiatry at the Strand Hotel, Tuesday afternoon, February 3, 1948. The panel discussion was the highlight of the Community Day Tea held by the *Woman's Auxiliary of the Atlantic County Medical Society* and the Woman's Club of Atlantic City.

Dr. Werner Hamburger acted as moderator for the discussion. Dr. Henry A. Cotton, Jr., and Mrs. Mario Petruzelli, counselor in the local public high school participated in the discussion.

The speakers and the audience were welcomed by Mrs. Edward H. Dyer, president of the auxiliary, and Mrs. Frank Schaeffer, president of the Woman's Club. Mrs. G. Ruffin Stamps arranged the program. Mrs. Stamps presented Mrs. Lodovico Mancusi-Ungaro, president of the State Auxiliary who was present at the meeting. Mrs. Mancusi-Ungaro spoke briefly on the evils of socialized medicine. Mrs. Edgar H. Warner, president of the Atlantic County Mental Hygiene Society was also presented, and Mrs. Warner urged the capacity audience to back the newly-formed Mental Hygiene Society.

Burlington County

Mrs. John C. Voss,
Chairman, Press and Publicity

On December 16, 1947, the Annual Christmas party and business meeting of the *Auxiliary to the Burlington County Medical Society* was held at the home of Mrs. Joseph Kuder of Mount Holly, N. J.

This meeting brought to a successful conclusion the drive to augment the Nurse Scholarship Fund. A sum sufficient for the nurse's second year training was realized.

A report was made by Mrs. William Bray, public relations chairman, on the special meeting held in Atlantic City, December 10, 1947, relative to the establishment of the four point health program for public school children throughout the state. Members representing Burlington County who attended were Mrs. Gerald McDonnel, state treasurer; Mrs. E. Vernon Davis, president; Mrs. Winfield Betts, president-elect; Mrs. John C. Voss, first vice-president, and Mrs. William Bray.

Essex County

Mrs. Asher Yaguda,
Chairman, Press and Publicity

The February meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on Monday, the 23rd, at the Academy of Medicine in Newark. Guests were Dr. Jules Sobin and Mr. William Hargrove.

Dr. Sobin, former Colonel in the Army with forty-seven months service in the Asiatic Pacific Theater, spoke on the "Neuropsychiatric Aspect of Veterans at Lyons Hospital". Dr. Sobin is Neuropsychiatrist in charge of Acute Service at Lyons and Chief of Neuropsychiatry at City Hospital and St. Michael's Hospital in Newark.

Mr. William Hargrove, well known as principal of Ridge Street School and Elliott Street School, discussed "Art Through the Ages". He illustrated his talk with slides.

The remainder of the afternoon was devoted to a tea in honor of the new members of the auxiliary. Mrs. Daniel E. Kavanaugh presided.

Hudson County

Mrs. Morris Bresev,
Chairman, Press and Publicity

With Mrs. William J. Gleeson, the vice-president in the chair, the regular meeting of *The Woman's Auxiliary to the Hudson County Medical Society* was called to order. The meeting was held at the Young Women's Christian Association Building on January 5, 1948.

During the meeting the resignation of Mrs. Louis Perkel, president was read and accepted with regret. Mrs. Perkel recently underwent a major operation and has been forced to forego all ac-

tivities for the time being. Mrs. William J. Gleeson succeeded Mrs. Perkel as president.

The afternoon's program consisted of a talk, *"Broadway on Review"*, by Mrs. Thelma Lippe.

Plans are under way for a luncheon, fashion show and bridge on January 24, 1948, at the Fairmount Hotel, Jersey City, with Mrs. Samuel Scott as chairman.

The next regular meeting will be held February 2, 1948.

Middlesex County

Mrs. Robert B. Walker,
Chairman, Press and Publicity

The regular monthly meeting of the *Woman's Auxiliary to the Middlesex County Medical Society* was held at Oak Hills Manor, Metuchen on January 21, 1948. Following a luncheon Mrs. Irving Sosin of Highland Park spoke on "Current Medical Legislation".

Mrs. Sosin, an attorney, is a graduate of New York University School of Law, a member of the Essex County Bar Association, Legislative Chairman of the New Brunswick Woman's Club and is on the Board of Directors of the Jewish Community Center. She formerly practiced law in Newark.

Following the program, Mrs. Nathan Karshmer conducted a business meeting.

Monmouth County

Mrs. Irving Baer,
Chairman, Press and Publicity

The first monthly luncheon meeting was held Tuesday, October 21, 1947, at the Molly Pitcher Hotel, Red Bank. Mrs. Andrew Dedick acted as hostess.

Mrs. Norman Nathanson, president, reported on her attendance to the State Executive Board Meeting held in Trenton, October 13, 1947.

Our Auxiliary has two statewide projects which will be organized on a county level. First is public relations program "Improving the Health of the School Children of New Jersey".

The second is a request from the Health Education Bureau of the American Medical Association for the Auxiliary to enlist the aid of the local radio station for the broadcasting of health talks made up by this bureau. The initial series assigned to our county is entitled "What to do Until the Doctor Comes". This is a public service for the community welfare and has been accepted by station WCAP, Asbury Park, to be broadcast early next month.

It was voted by the group to place the magazine *Hygeia* by gift subscription, into all the local high schools.

Mrs. Maxwell Colby was appointed by the president to fill the unexpired term of Mrs. Joseph Bossone as public relations chairman.

The second monthly luncheon meeting was held at the Stone Posts Inn, Spring Lake, Tuesday, November 18, 1947. Mrs. Frederick Hummell acted as hostess. Mrs. Norman Nathanson, president, presided.

The public relations committee reported that the first meeting of the Monmouth County School Health Council will be held Thursday, December 11, 1947, at 8 p. m., in the Staff Library of the Monmouth Memorial Hospital. This Council is made up of educators, school health and board representatives, P.-T. A.'s and professional men and women. The committee also reported that a series of broadcasts entitled "What to do Until the Doctor Comes", sponsored by the A.M.A. is now being heard weekly over station WCAP, Asbury Park, Saturdays at 10:30 a. m.

Mrs. Andrew Dedick reported $100 cleared at the recent card party held in Spring Lake at the Beau Rivage and Ed and Pegeen Fitzgerald of Station WJZ, New York, announced the coming of the card party earlier in the week. Mrs. Joseph Villapiano presented corsages to the committee commending them on their work in making it a success.

The annual Christmas project was discussed. The final plan to give Allenwood Hospital a check for $100 toward a television set was agreed upon.

Mrs. Norman Thetford was introduced as a new member from Eatontown.

Ocean County

Mrs. Harvey Rinzler,
Chairman, Press and Publicity

The Woman's Auxiliary of the Ocean County Medical Society held its January 14th meeting at the Cabana, Lakewood. The following members were present for this social dinner affair: Mesdames Alpert, Jaffee, Sickel, Carmada, Goldstein, Towbin, Smith, Gartlan, Licht, Taylor, Szold and Rinzler.

After several committee reports, a letter from Miss Marie Licht was read, which thanked the Auxiliary for purchasing a new range for Paul Kimball Hospital. The state of the treasury was discussed and a decision made to hold a White Elephant Auction Sale at the next meeting.

Warrren County

Mrs. Herman Smith,
Chairman, Press and Publicity

Dr. Arthur Zuck, psychiatrist of Washington, N. J., was the principal speaker at the meeting of the *Woman's Auxiliary to the Warren County Medical Society* which was held November 25, 1947, at Morries Acres.

Dr. Zuck's subject was *Mental Hygiene and Mental Health.* He stressed the roll of economic and social conditions in mental disorders and the need of child guidance and parental guidance clinics. He asserted that the prevalence of mental disorders calls for their recognition in early childhood to prevent subsequent behavior abnormalities, juvenile delinquency and outright criminality. He concluded: "A program for better understanding of mental health should be planned by local communities".

Mrs. Walter Boquist, president, announced that Mrs. Lodovico Mancusi-Ungaro, state president and Mrs. Robert B. Walker, president-elect of the State Auxiliary would be guests at the next meeting to be held in January.

BOOK REVIEWS

Aphasia: Guide to Retraining. By Louis Granich. Pp. 108. New York. Grune and Stratton, 1947. $2.75.

This interesting compendium aims at an overall picture of the many kinds of speech defects. It describes, classifies and reviews the several types of aphasia, and explores the functional and organic causes. With the laudable purpose of bringing order out of the chaos now existing in the terminology and concepts of aphasia, Dr. Kranich sets up a scheme of his own. Since he uses arbitrary alphabetical symbols, a course in mnemonics is needed to aid the reader in recalling what the code letters mean. There is a good chapter on brain injury which will hold the attention of any neurologist, psychiatrist or industrial surgeon. The author analyzes the cause and nature of "traumatic neurosis" and other phenomena following head injury and properly points out that it is not the *fact* that the head was injured which caused the neurosis but rather the *knowledge* of that fact. The injury thus does not really cause the neurosis. When trauma afflicts a basically unstable person, the provocation is sufficient to spill the neurosis out of its container and into the clinical picture.

Cases are grouped together and cited in the appendix. This is a new and welcome technic for presenting such material—better than scattering cases throughout the text, since it enormously simplifies reference. The text is readable, the format excellent, and book highly recommended for any one interested in this somewhat specialized field.

L. S. Hinckley, M.D.

Gastritis. By Rudolph Schindler, M.D. Pp. 462 with 2 plates and 96 figures. New York, Grune & Stratton, 1947. $8.75.

Dr. Schindler has had much to do with the perfection of the flexible gastroscope, and has spent the last twenty years proclaiming its value in gastroenterology.

Older concepts of gastritis were based on post mortem specimens, post-operative sections, or clinical observations. The author refutes many of these concepts, since with the gastroscope the living stomach wall has for the first time been observed.

The author deals with the classifications of gastritis, suggesting one of his own. Following this, there is a discussion of the histopathology of the normal stomach, and that seen in each type of gastritis.

In the next section, Dr. Schindler correlates gastroscopic findings with symptomatology. After that, there is a summary of 55 selected cases. The bibliography contains 401 references, including Thornton Wilder's *The Bridge of San Luis Rey*, Spengler's *Decline of the West*, and an article in *Popular Science* Magazine. Colored plates, each containing six pictures, offer artists' conceptions of gastroscopic views. The book is concluded with 96 illustrations dealing with the microscopic picture of various types of gastritis. Here we find such involved captions as, "Chronic Atrophic-Hyperplastic Tumor-Forming Gastritis", "Chronic Hypertrophic Proliferative Ulcerative Gastritis Tumor-Forming", or "Chronic Atrophic Proliferative Gastritis Tumor-Forming".

Dr. Schindler has done much for gastroenterology both in Europe and in America. Not only did he advance the gastroscope technically, but he has written prolifically about what he has seen with it. There is no need to dwell on the limitations of the gastroscope since that becomes immediately apparent to any specialist who uses it. One can readily criticise the long-winded classifications of gastritis of Dr. Schindler and others. Actually the instrument will stand the test of time only as it increases our accuracy in diagnosing diseases of the stomach. Whether all these gastric mucosal patterns it has uncovered are clinical entities is highly problematical. Books like Schindler's at least keep the ball in play. While the book has little value to any one other than the specialist in the field, it is interesting to see the enormous literature that has grown up about the gastroscope and gastritis.

Andrew J. V. Klein, M.D.

One Hundred and Forty Million Patients. By Carl Malmberg. 242 pages. Reynal and Hitchcock, New York, 1947, $2.75.

The author addresses himself to doctors who, not having time to delve deeply into the social and economic aspects of medicine "tend to accept what they read in their professional journals". As a result, "many physicians have been indoctrinated with the notion that health insurance is the devil's own invention—a plot against their own integrity and their patient's welfare".

Carl Malmberg has been a public relations advisor, information specialist for the United States Public Health Service and chief investigator for the United States Senate Subcommittee on Health and Education.

His thesis is that what is needed to provide adequate health protection in this country is better financial support and coordination of medical research; reorganization of medicine on a group-practice basis so that present and future medical knowledge can be applied without "so much waste"; and a system of group payment for medical services which would bring good medical care within reach of all the people, regardless of income or geographical location. The various existing plans operating throughout the country are discussed. These include the voluntary plans, such as Blue Cross, Medical Society plans, commercial health insurance, and group-practice plans—all of which the author regards as inadequate and expensive. He favors a compulsory plan as exemplified by a federal health insurance program.

The book contributes toward an understanding of the important problem of medical care.

I. J. Bernstein, M.D.

Practical Clinical Psychiatry, by E. A. Strecker, F. C. Ebaugh and J. R. Ewalt. 476 pages. 35 illustrations. Sixth edition. The Blakiston Company, Philadelphia, 1947.

Mature practitioners of psychiatry have been complaining for years that medical schools do not give students a proper orientation to this specialty. The survey by Porter and Davidson, reported earlier this year, spotlighted the fact that the number one grievance was that students had inadequate emphasis on the psychoneuroses, that they were led to believe that psychiatry was essentially a matter of labelling psychotics. The second major defect in psychiatric teaching was an altogether inadequate stress on therapy. The new edition of the Strecker-Ebaugh-Ewalt book indicates that these deficiencies will continue. Here is probably the most popular medical students' psychiatric text-book in the country. It devotes only 55 pages to the psychoneuroses (some 11 per cent of its space) in spite of the fact that psychoneurotics will constitute about 80 per cent of the psychiatric case-load of a practitioner's office. While the authors give both the A.P.A. and the Army classifications of mental disease, they cling to the obsolete term "constitutional psychopathic inferior", although the phrase passed into official desuetude several decades ago. This, of course, serves to confuse the medical student, who learns from this book that psychopaths are "inferiors" and learns from psychiatric practitioners that they are not.

There is a long chapter on psychopathologic problems of childhood. The usefulness of this section may be best illustrated by the following verbatim transcript of a typical paragraph "Different children react differently to the same environment. All men are not born equal. This is true of wide variations in their intellectual endowment." Suffixed to the book is a seven-page chapter on "pathologic drinking" which lays down "rules" for treating the chronic alcoholic. Here we are told, for instance, that frankness, patience, willingness and cooperation are essential!

The psychoses are compactly described, and the book as a whole is an excellent manual for the medical student who wishes to focus attention on the institutionalized insane, and who has other sources for information on the far greater number of non-institutionalized psychiatric problems.

W. S. Schram, M.D.

Peripheral Vascular Disease. By E. V. Allen, M.D.; N. W. Barker, M.D., and Edgar Hines, M.D. Pp. 871. Philadelphia Saunders 1947. $10.

Peripheral vascular diseases represent to many physicians a hodgepodge, in which diagnosis and differentiation are haphazard, and treatment uncertain, ineffectual and controversial. The authors, from their experience at the Mayo Clinic note that it is seldom that a student comes to them with anything but the most rudimentary knowledge of what is required for adequate examination of the peripheral circulation.

This volume then is an attempt to organize and delineate clearly the reasonably well understood group of distinct disorders referred to as "peripheral vascular disease". Emphasis is upon personal experience in regard to a wide range of diseases; it is therefore a cooperative effort. The first section of the book deals with a definition of terms, anatomy of the peripheral blood vessels, and a detailed discussion of the diagnosis of vascular diseases, including special methods of investigation. Subsequent portions deal with the individual diseases, such as Raynaud's disease, scleroderma, erythromelalgia, Buerger's disease, aneurysms, arterio-venous fistulae, diseases of the veins and lymphedema.

Approach of the authors is essentially medical, and they devote a full section to a discussion of the medical armamentarium as well as various special technics. They list the controversial points and express definitely their own opinions and preferences. A section is devoted to surgical treatment of certain conditions, and the special technics involved.

The book is thorough in its treatment of the subject. Some sections are preceded by biographic notes on outstanding contributors to our knowledge of peripheral vascular disease. The bibliography is thorough including both recent and early references. Illustrations are plentiful and the index is adequate.

This volume satisfies a definite need and is highly recommended.

I. J. Bernstein, M.D.

The Chest; A Handbook of Roentgen Diagnosis. By Leo G. Rigler, M.D., Professor and Chief, Department of Radiology, University of Minnesota. Year Book Publishers, Chicago, 1947. $6.50.

This handbook opens with a discussion of the radiologic methods of the examination of the chest —fluoroscopy and roentgenography. Detailed steps in procedure are presented in concise form.

A chapter on the "Normal Chest" deals with normal roentgen findings, anatomic variations and artifacts. And, we are reminded that "tumors of the chest wall, nodules in the skin, such as occur with neurofibromatosis, large warts or moles and foreign bodies in the chest wall cause shadows superimposed on the lung fields that are often indistinguishable in the ordinary single roentgenogram from intrathoracic lesions. Braids of hair, if permitted to cover the apexes during the exposure, may simulate an abnormality such as tuberculosis."

The pathologic conditions are discussed under the standard subdivisions. The illustrations are plentiful, well chosen, and perhaps the leading feature of this small volume. They are, of necessity, greatly reduced in size. Nevertheless they remain clear and their salient features are readily visualized.

Joseph Israel, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **March, 1948** **No. 3**

THE DIAGNOSIS of active pulmonary tuberculosis rests on three pillars — symptoms, roentgenology, and the finding of the tubercle bacillus. Of this triad the first two are not specific for the disease; X-ray shadows can only suggest the diagnosis, and symptoms may be vague or appear late in the disease. Physical signs and tuberculin tests have definite but limited diagnostic significance. The demonstration of tubercle bacilli, however, establishes the diagnosis beyond dispute. In this disease, therefore, the laboratory can render a unique service to the physician. It may be more fully utilized if the possibilities and limitations of bacteriological methods are understood.

THE BACTERIOLOGICAL DIAGNOSIS OF PULMONARY TUBERCULOSIS

Diagnostic significance of bacteriologic findings. The culturing of sputum and/or gastric contents is of paramount importance if a complete diagnostic picture is desired. If frequent and technically expert studies are made both positive and negative results have a diagnostic importance equalled by few laboratory procedures in any disease. Under the conditions just stated, the diagnostic significance of bacteriologic findings may be described as follows:

(1) Tubercle bacilli are demonstrable in practically 100 per cent of patients with frankly active pulmonary tuberculosis. Exceptions to this dictum are: In a considerable percentage of patients with hematogenous disseminations and without cavities, tubercle bacilli cannot be demonstrated for long periods of time. In about 20 to 30 per cent of patients with minimal, asymptomatic tuberculosis, tubercle bacilli cannot be demonstrated with the methods at present available.

(2) Failure to find tubercle bacilli on frequent subsequent examinations in patients who previously had positive findings, strongly suggests that the process has become arrested.

(3) Failure to find tubercle bacilli on at least ten specimens, if all available methods have been used, practically excludes the diagnosis of active pulmonary tuberculosis with the exceptions noted above.

(4) Demonstration of tubercle bacilli in sputum or gastric contents proves, for all practical purposes, the existence of active *pulmonary* tuberculosis. In rare cases, however, tuberculous lesions occur in the upper respiratory tract (including trachea and large bronchi) which may shed bacilli in the absence of demonstrable pulmonary tuberculosis. Nonpathogenic acid-fast bacilli, which resemble but are *not* tubercle bacilli, have occasionally been observed and cultured from human secretions. In case of doubt, acid-fast bacilli must be identified by animal inoculation.

The diagnostic significance of negative bacteriologic findings depends on the clinical and roentgenological picture: In patients with moderate or large amounts of purulent sputum, with obviously active pulmonary lesions, even three or four negative smears and concentrates are a strong argument against the diagnosis of pulmonary tuberculosis. On the other hand, in patients with minimal or no sputum and in whom the pulmonary lesions are small, without cavitation and of questionable activity, negative bacteriologic findings assume diagnostic importance only after many cultures have remained negative.

Prognostic significance of bacteriologic findings. Disappearance of tubercle bacilli from previously bacilliferous secretions suggests that the process has become arrested. Absence of tubercle bacilli, at least in smears and concentrates, is one of the requirements in the National Tuberculosis Association's Diagnostic Standards for classifying a patient as "apparently arrested" or "arrested".

Fluctuations in the number of tubercle bacilli in sputum and gastric contents are frequent and have little prognostic significance. Grading of sputum records by the Gaffky scale should be discouraged. For clinical purposes it is sufficient to grade reports according to gross distinctions, such as "many bacilli", "few bacilli" and "very rare" on direct smear; "bacilli present only in concentrates"; "sputum or gastric positive on culture".

Methods for reasonably accurate estimation of the number of bacilli have been worked out but they are too complicated for routine use.

An irksome problem is the patient who, after adequate treatment, fulfills the requirements for the classification "arrested", but from whose sputum or gastric contents an occasional positive culture is obtained. Many such patients live normal lives without breakdown. There is, however, some evidence that such patients reactivate their disease more frequently than those in whom all cultures are negative.

Evaluation of bacteriologic methods. Under the assumption that competent laboratory work is done, one may expect that *cultures* of sputum and gastric contents may together contribute between 30 and 40 per cent of the total positive findings. Between 60 and 70 per cent of the new admissions, upon whom a positive diagnosis will be established by the examination of smears and concentrates, will be so diagnosed by one of the first three examinations.

These figures indicate general trends; they are, of course, largely dependent on the type of patients under consideration.

Even with the best available methods it is not possible to demonstrate tubercle bacilli in all patients with active tuberculosis. This is due to technical deficiencies and because some patients expel bacilli only at irregular intervals.

Collection of Specimens. Sputum: Sputum is collected in sterile wide-mouthed bottles with sterilizable screw-tops. At least 15 cc. should be collected, even if it takes several days to do so. Patients must, of course, be instructed to collect only sputum—that is, secretions coming up *from below the larynx*, and *not saliva or postnasal discharge.*

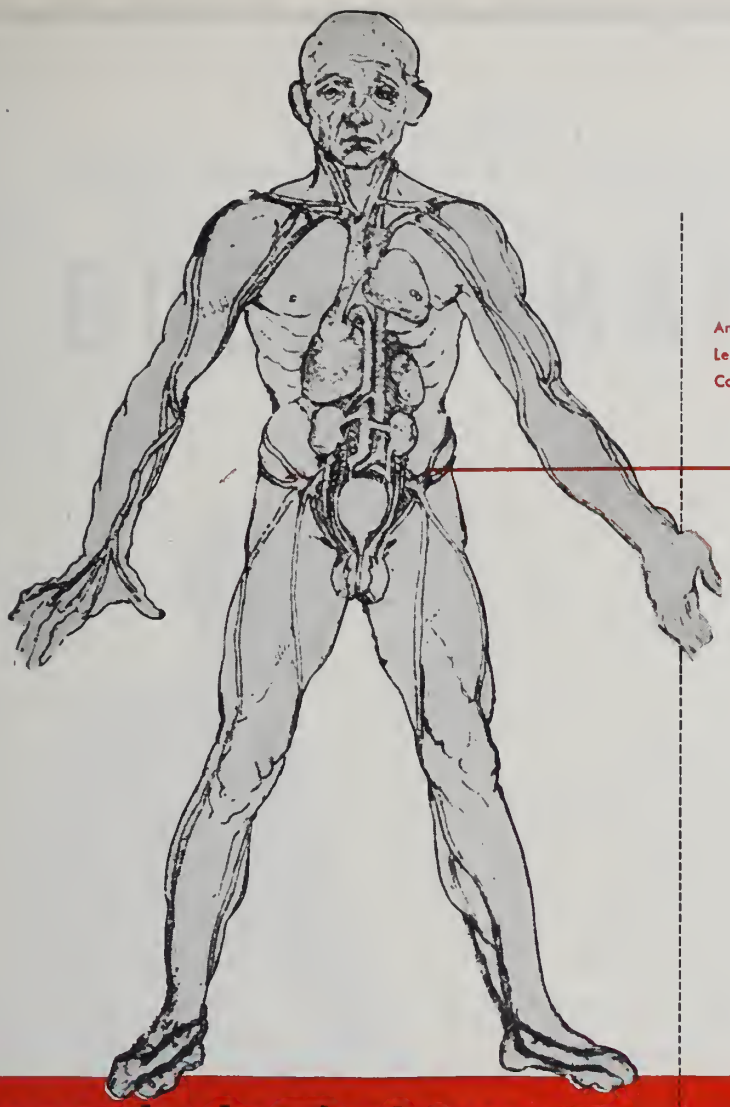
Gastric contents: Fasting gastric contents must be examined in all patients who have no sputum and those in which sputum examinations have been negative. Such specimens must be sent to the laboratory immediately after withdrawal and must be promptly prepared for culture, since prolonged contact with gastric juice seems to impair the viability of tubercle bacilli.

The Bacteriological Diagnosis of Pulmonary Tuberculosis, Max Pinner, M.D., Veterans Administration Technical Bulletin, October 10, 1946. (Original paper includes laboratory directions and bibliography.)

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Articles selected for "Tuberculosis Abstracts" are chosen for their interest and value to physicians generally. Effort is made to avoid highly technical papers that would concern the specialist only. "Abstracts," prepared in the Health Education Service of the National Tuberculosis Association, are approved by the Medical Advisory Committee on Health Education of the American Trudeau Society and by the author of the original article prior to publication. The circulation of "Tuberculosis Abstracts" is approximately 80,000 per month.

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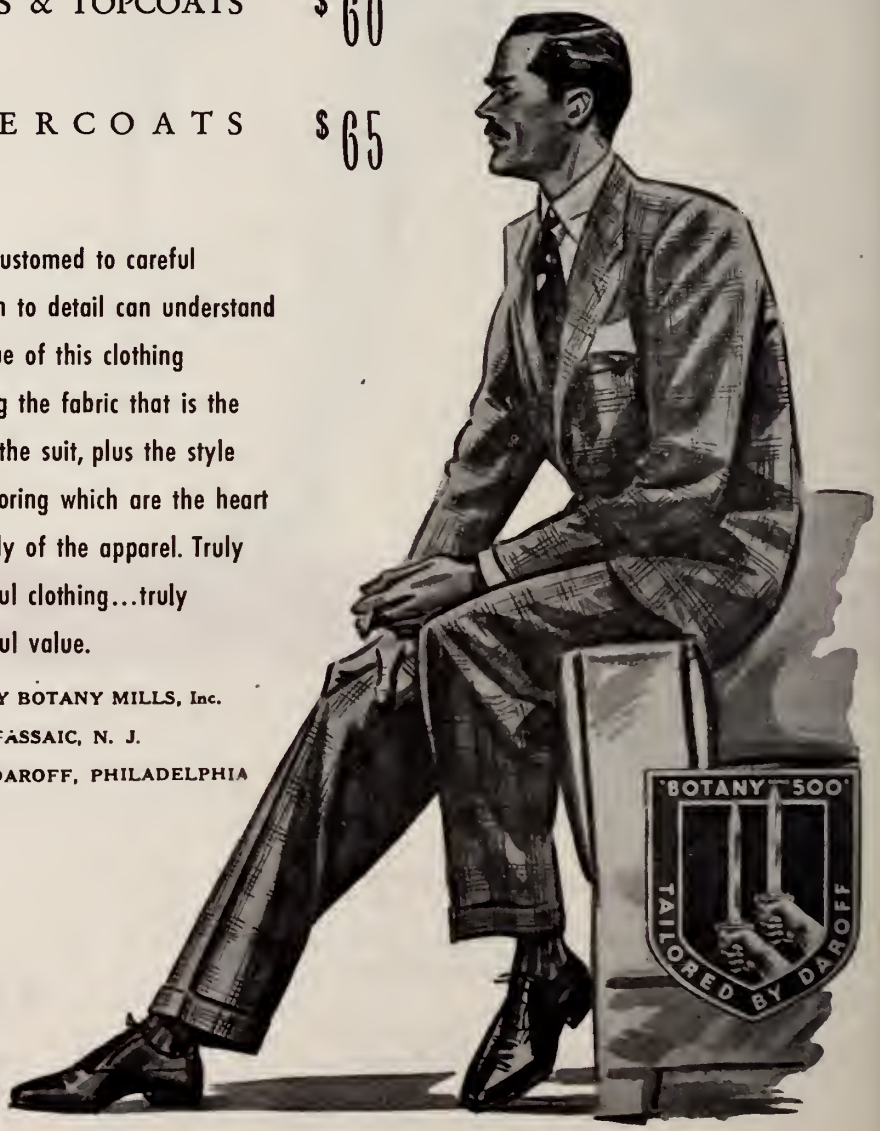
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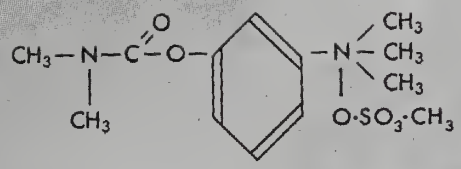
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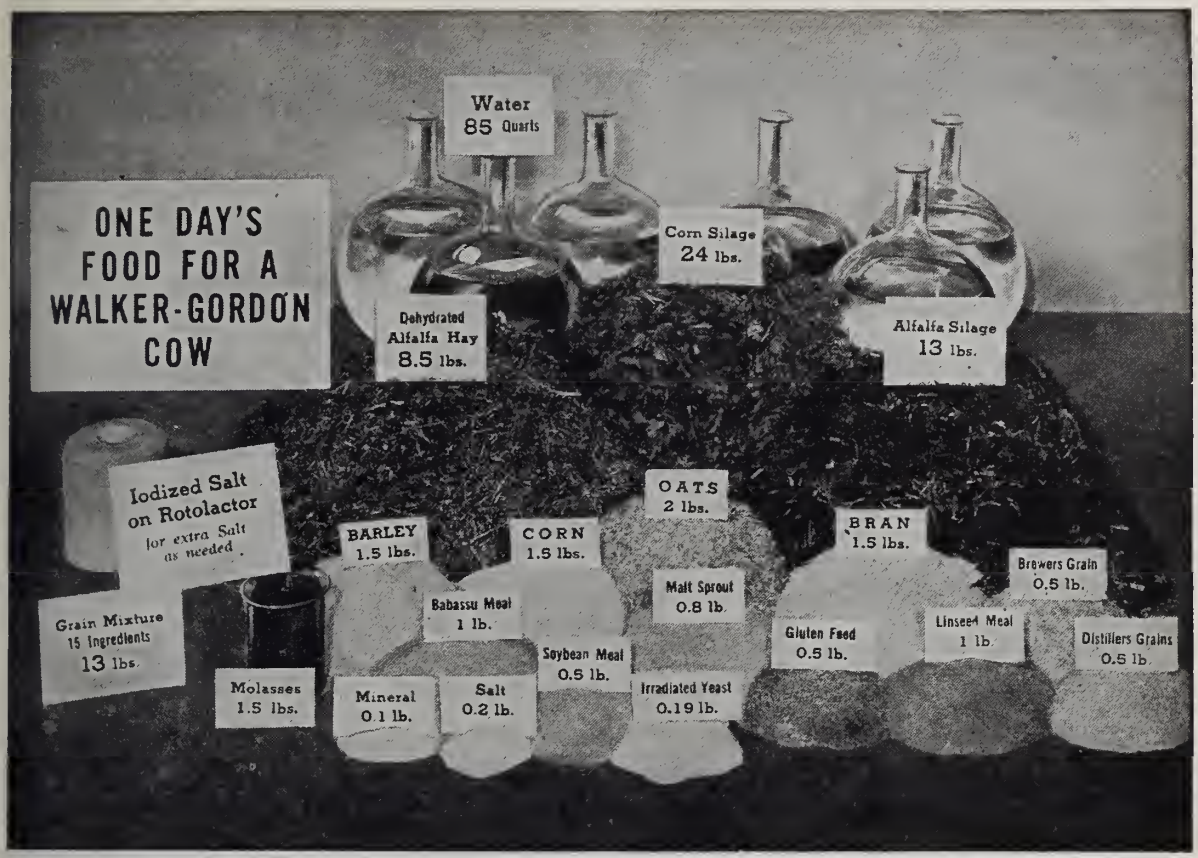
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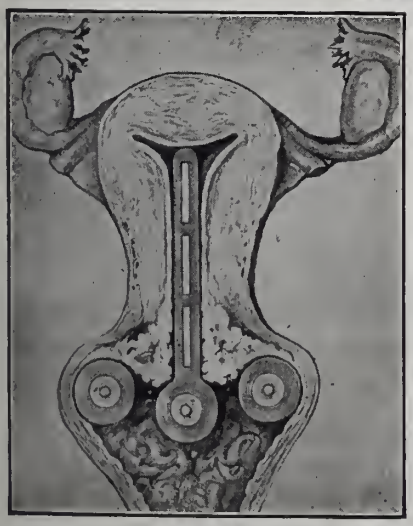
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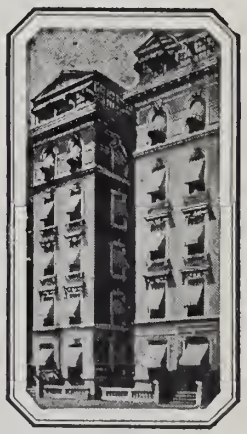
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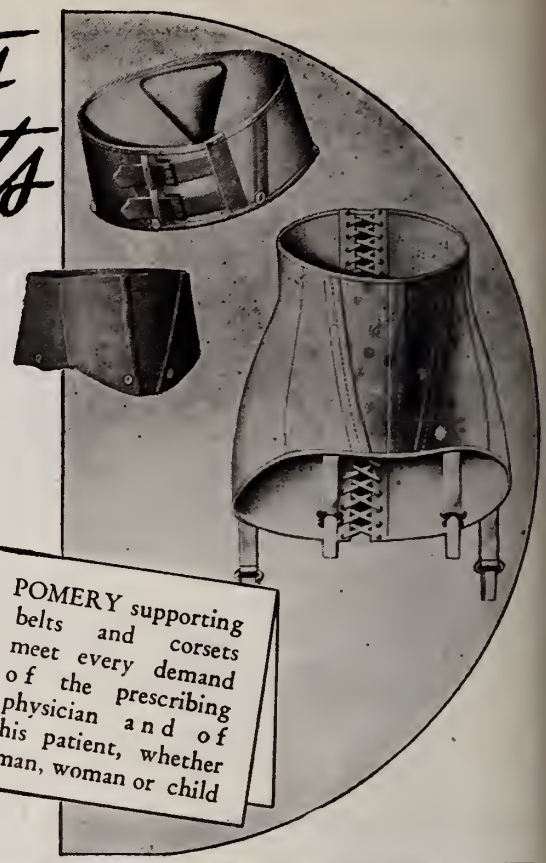
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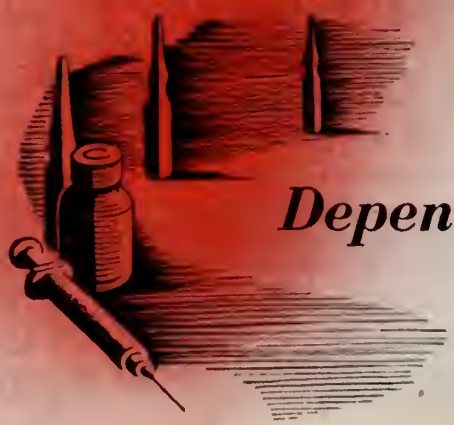
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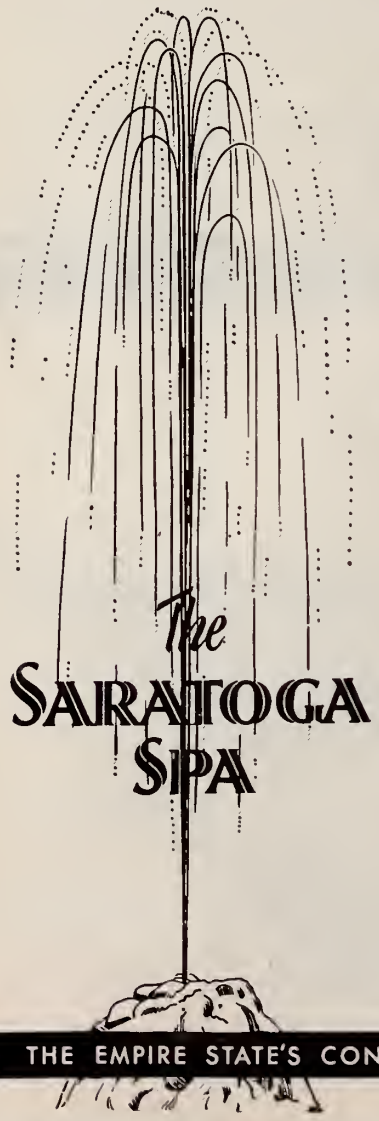
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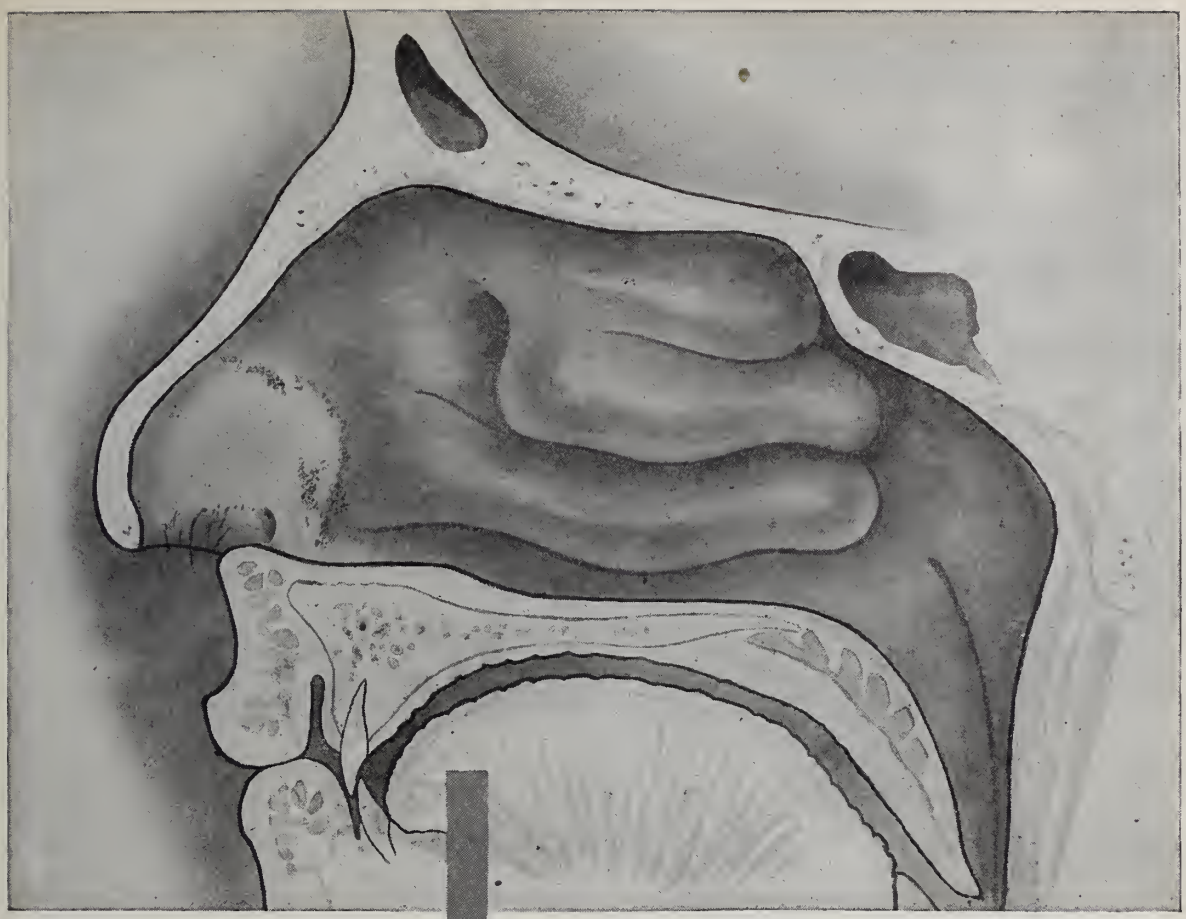
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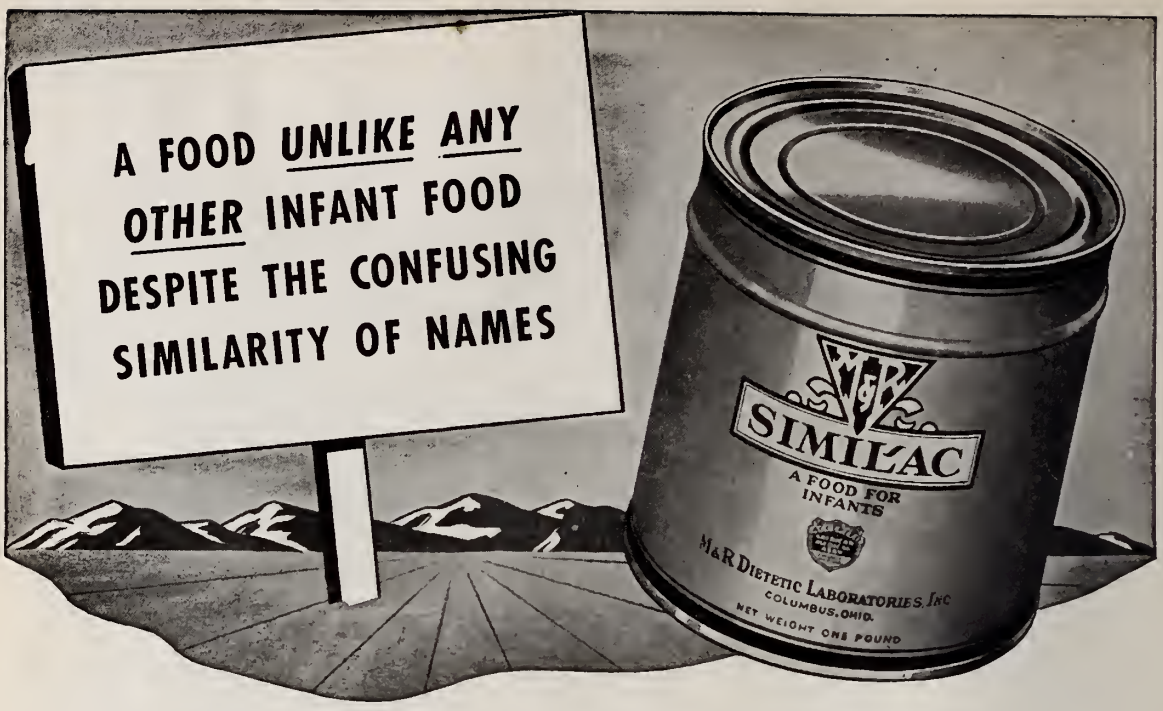
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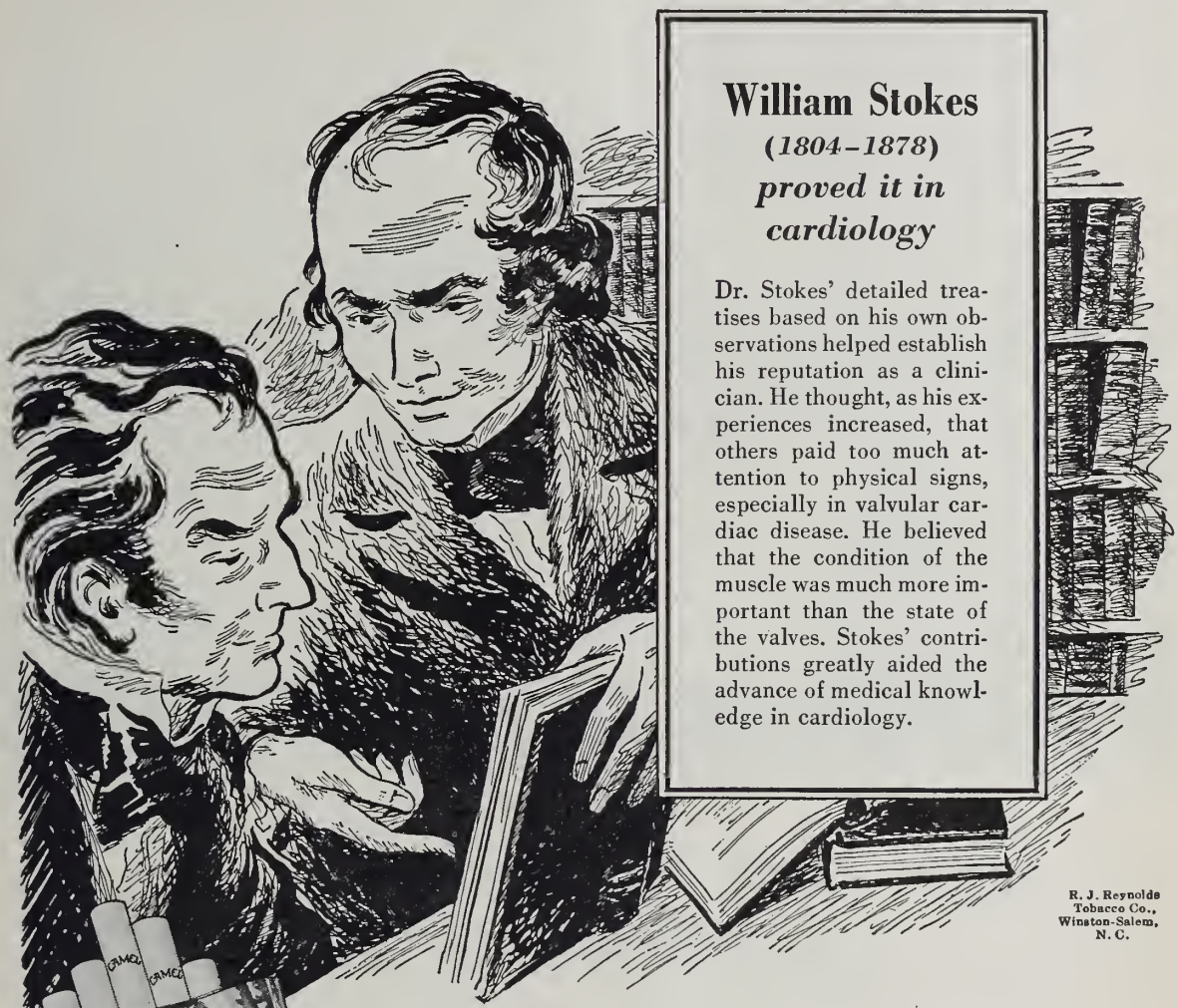
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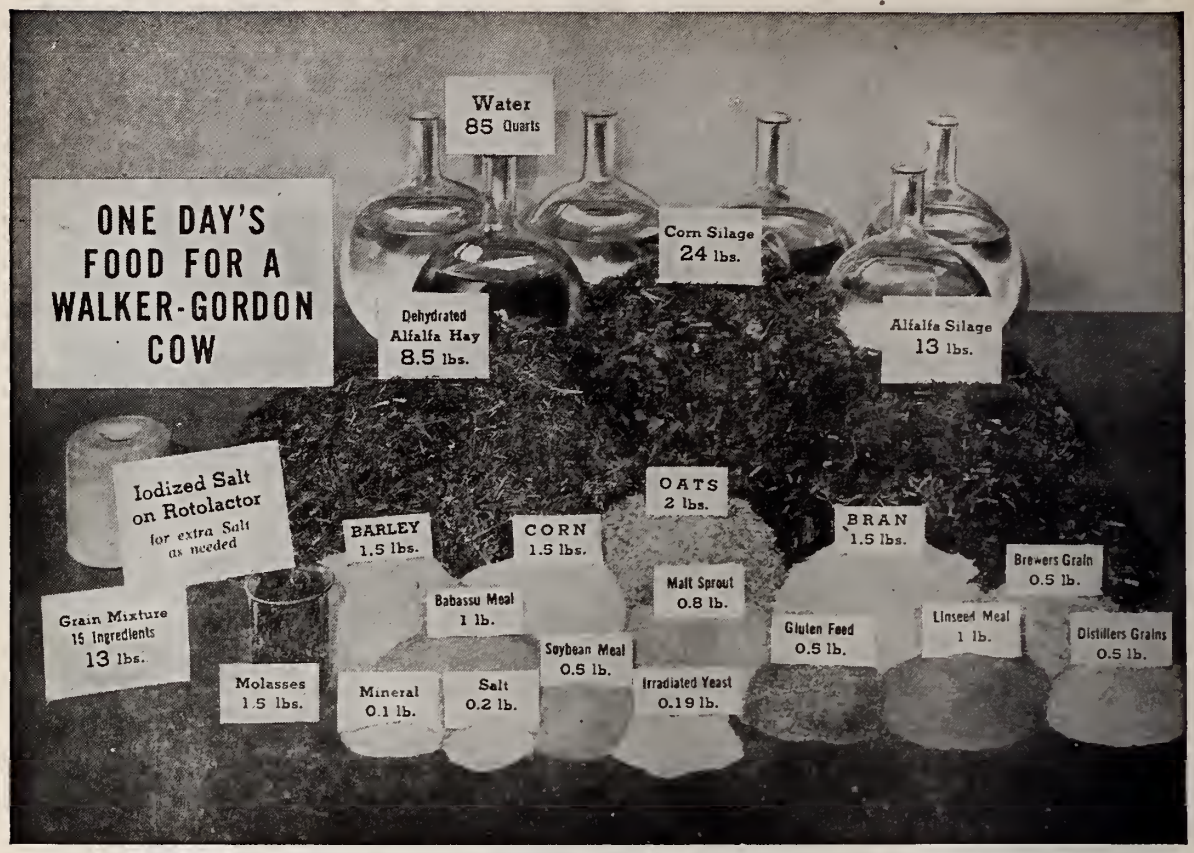
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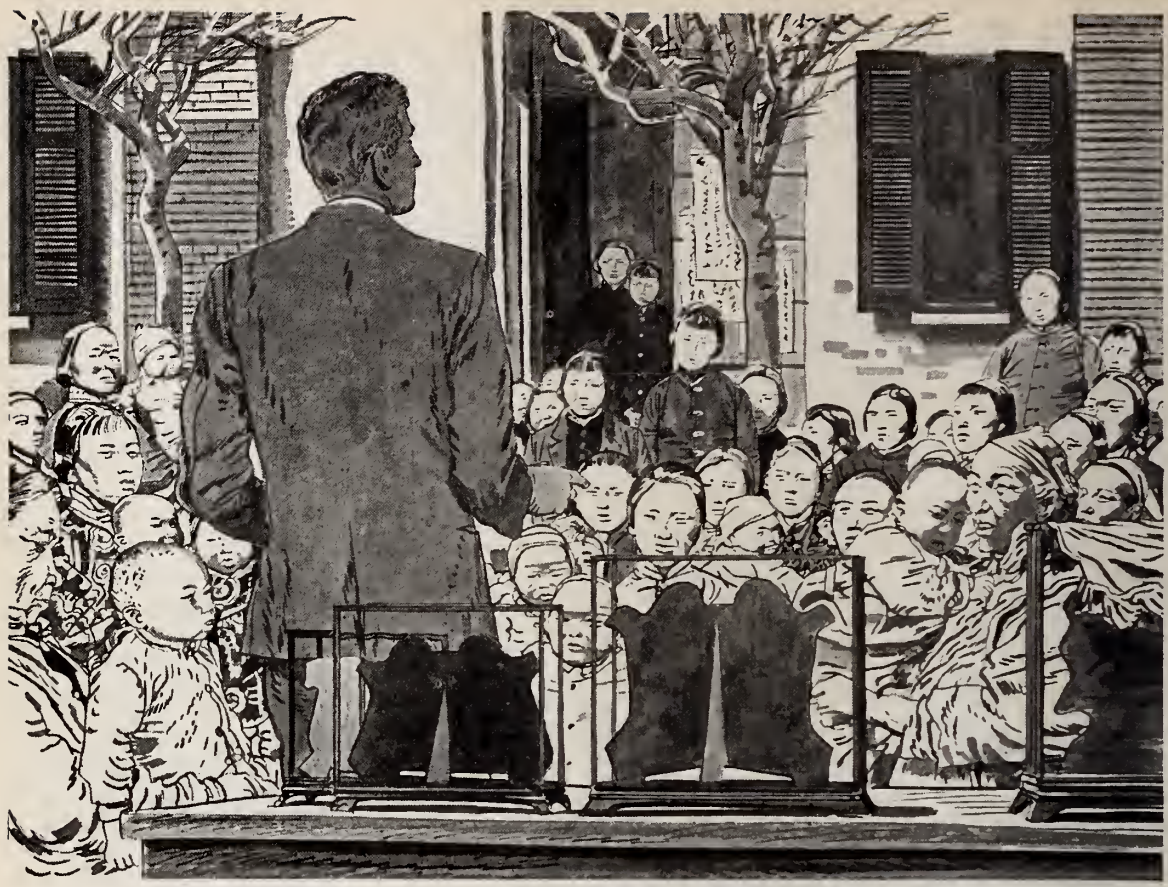
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1. Arbesman, C. E. et al. Jl. of Allergy 17:275, Sept. 1946.
2. Fuchs, A. M. et al. Jl. of Allergy 18:385, Nov. 1947.
3. Feinberg, S. M. and Friedlaender, S. Am. J. Med. Sci. 213:58, Jan. 1947.

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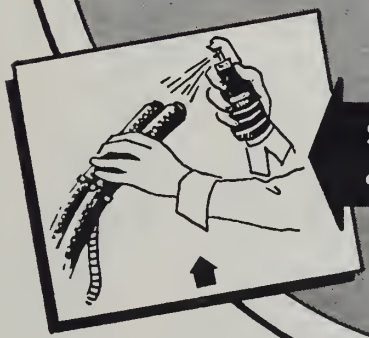
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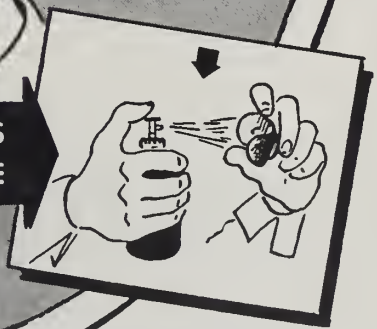


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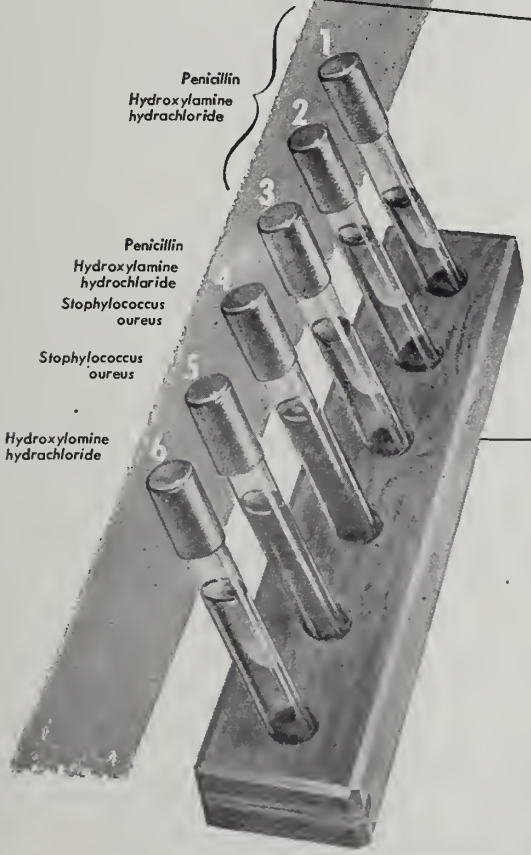
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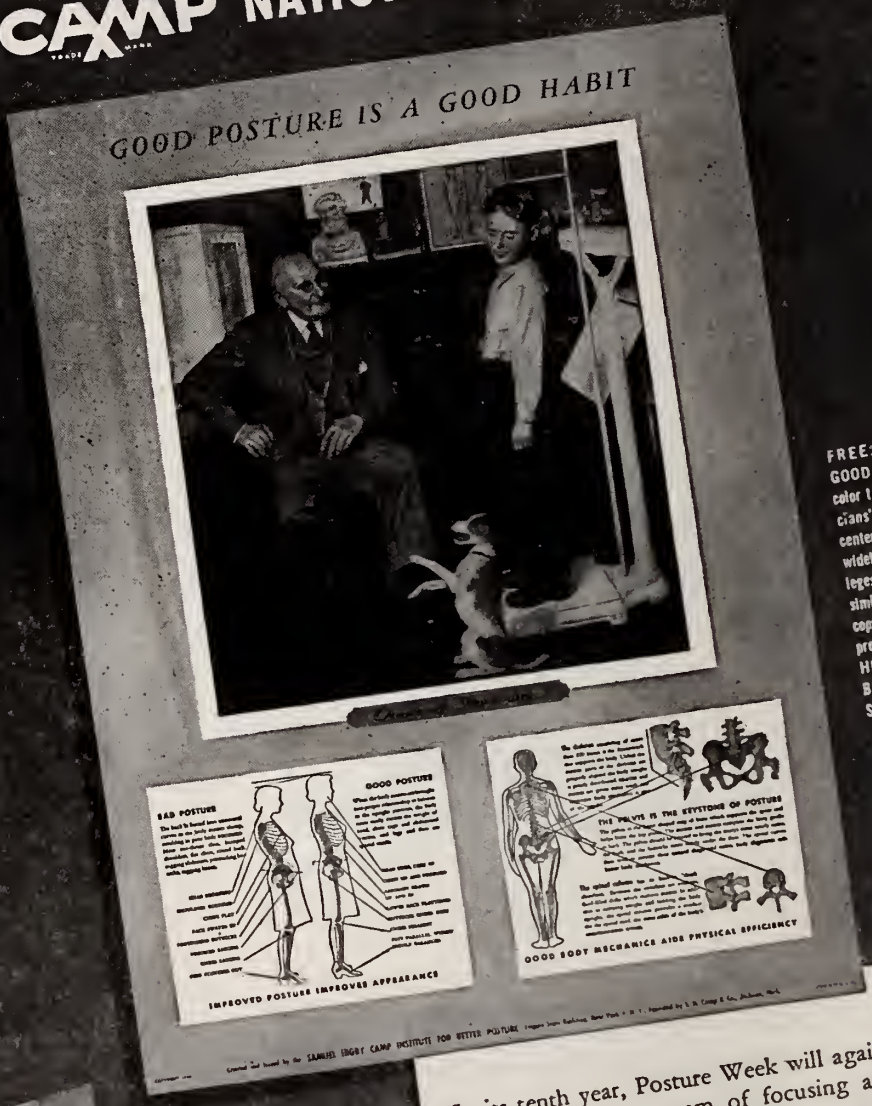
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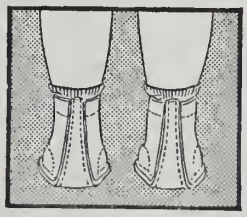
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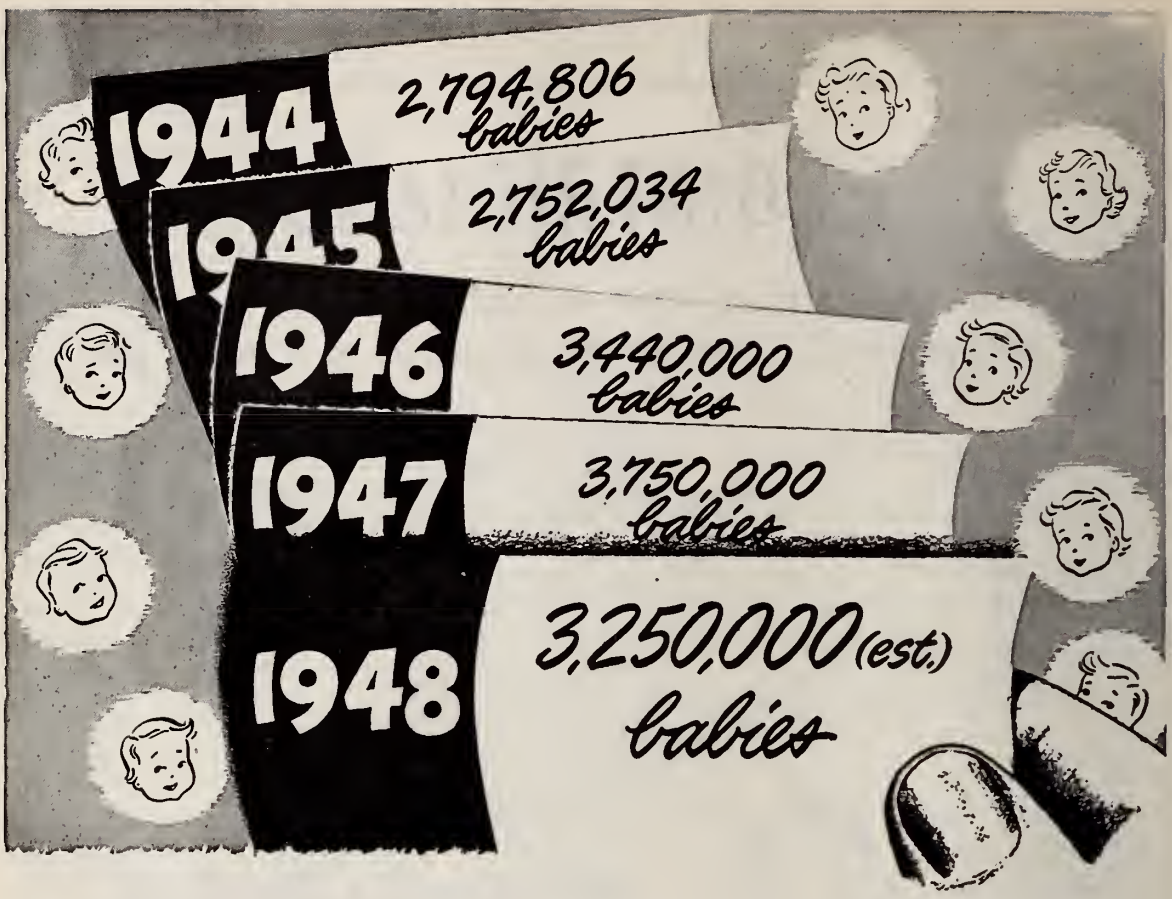
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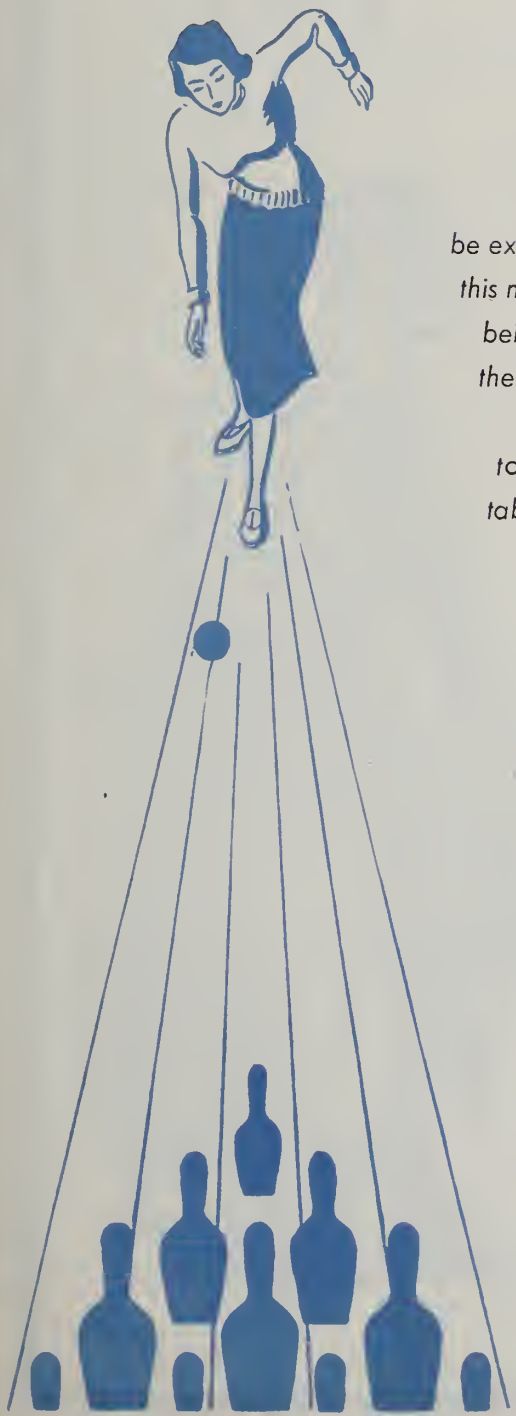
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OF
THE MEDICAL SOCIETY OF NEW JERSEY

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HENRY C. BARKHORN, M.D.,
Chairman.



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THE PRESIDENT'S PAGE

DOES NEW JERSEY NEED A MEDICAL SCHOOL?

"The doctor shortage is nearing crisis proportions. It is the bottleneck on all lines of advance towards national health." So says Oscar Ewing, Federal Security Administrator, who estimates that by 1960 the net physician deficit will surpass 25,000! This, he predicts, will be the situation unless existing or new medical schools increase the number of students enrolled each year. Dr. Fishbein speaking for the American Medical Association takes sharp issue with Mr. Ewing on this. He points out that there is now available one physician to every 750 persons in the United States and that this proportion will be about the same in 1960 with existing facilities. It is probable that neither Mr. Ewing or Dr. Fishbein is wholly correct and that an increased number of doctors will be needed to supply our greater demand for physicians, not only private practice, but also for industrial, public health, military, Veterans Administration and other organized medical requirements. Mr. Ewing offered three proposals for government aid to relieve the situation:

1. Grants of $50,000,000 annually to medical schools for operating expenses.
2. Grants to medical schools for construction of new and additions to existing buildings, the grants not to exceed half the total cost.
3. Scholarships of two types to increase the number of persons training for medical, dental, nursing and public health service. One group would be state scholarships for medical personnel who can practice anywhere they desire, and the other would be federal scholarships for students who agreed to serve for a time in special shortage areas following graduation.

High grade medical schools add greatly to the standards of medical practice and to the general health level of the areas in which they are situated. Although our state has a population of about 4,500,000, we do not now have a medical school of any kind within our borders. With at least ten applicants for each place in a

medical school, prospective medical students from New Jersey are at a distinct disadvantage, being obliged to seek admission to schools in neighboring states (particularly in New York and Pennsylvania), and often succeeding in finding a place only in a school far removed from this area.

At the present, facilities for education in all branches of learning except medicine and dentistry, are available to our college students. The Board of Trustees of The Medical Society of New Jersey has endorsed the principle of "an approved school of medicine under University auspices supported by revenue from general tax funds." Rutgers University is now in process of expanding and augmenting its existing facilities by the expenditure of $15,000,000 in the near future, with a total of $50,000,000 contemplated as a long range program. It is probable that a bond issuue of $75,000,000 for the expansion of existing facilities for education and welfare will be approved by the electorate in November. It is estimated that $10,000,000 would be required to construct and equip the necessary physical plant and that $500,000 would be needed each year for maintenance.

Now is the time for us to urge upon the Governor, the Legislature and Rutgers University, the need for a medical school in New Jersey, and further to urge that provision for such a school be included in the overall planning for education presently being actively discusssed.

The answer to the rhetorical question in the title of this message is, in my considered opinion, emphatically "yes."

Royal A. Schaaf, M.D.
President.

HOSPITAL AIDES IN NURSING SERVICE

The use of "practical nurses," "hospital aides" and others with substantial training is one obvious way of meeting the nursing shortage. As might be expected, hospitals and trained nurses are generally unenthusiastic about this suggestion. They fear it will debase standards of nurses' training, cause the public to confuse the trained and the "practical" nurse and complicate the educational program of the hospital. It is, therefore, with considerable interest that we note the highly successful experiment in training aides recently reported by the Mountainside Hospital. "Three months after the introduction of the program" we are told "the majority of head nurses wanted more hospital aides. We have improved the bedside care of patients. Letters frequently commend the work and attitude of the aides. Their services contributed largely to the opening of a section which had been closed."

It is to be noted that in the Mountainside Hospital experiment, the functions of the aides were clearly defined—and, what is more important, the functions *not* permitted to them were carefully laid down. Hospital aides do not give medications, take temperatures, have access to charts or participate in any sterile procedure. They do prepare unsterile surgical supplies, assist with serving meals, feed helpless patients, clean glasses and water pitchers, help patients into and out of wheel chairs, make beds, carry bed pans, and care for flowers. There is no good reason why a girl has to have an I.Q. of 125 and a course in bio-microchemistry to do those things. The trained nurse has finally achieved bona fide *professional* status (as attested by their Army grade and civil service classification). But there is still need for some one to fill ice water pitchers and tote bed pans. The creation of a subprofessional corps of aides seems like a good answer and the Mountainside experiment in New Jersey a fair test of the workability of that answer.

THE 182nd ANNUAL MEETING

of

THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY

April 26, 27, 28 and 29, 1948

DAILY SCHEDULE

SUNDAY, APRIL 25, 1948

8:00 p. m.—Finance and Budget Committee
Rowsley Room, 1st floor

MONDAY, APRIL 26, 1948

10:00 a. m.—Board of Trustees
Rowsley Room, 1st floor
Judicial Council
Bakewell Room, 1st floor
2:00 p. m.—House of Delegates
Viking Room, 13th floor
6:30 p. m.—Fellows' Dinner
Rowsley Room, 1st floor
8:30 p. m.—Nominating Committee
Bakewell Room, 1st floor

TUESDAY, APRIL 27, 1948

10:00 a. m.—Scientific Sections:
Medicine
Rutland Room, 1st floor
Pediatrics
Viking Room, 13th floor
Eye, Ear, Nose and Throat
Mandarin Room, 13th floor
1:00 p. m.—Auxiliary Executive Board
Solarium, Lounge floor
2:00 p. m.—Scientific Sections:
Gastro-Enterology and Proctology
Mandarin Room, 13th floor
Surgery
Rutland Room, 1st floor
Neuropsychiatry
Viking Room, 13th floor
Obstetrics and Gynecology
Benjamin West Room, 13th floor
3:30 p. m.—Auxiliary Tea
Solarium, Lounge floor
4:15 p. m.—School Health Program Conference
Viking Room, 13th floor
6:30 p. m.—Fellowettes' Dinner (by invitation only)
8:30 p. m.—Reference Committees
13th floor

WEDNESDAY, APRIL 28, 1948

9:30 a. m.—Scientific Sections:
Clinical Pathology
Tower Room, 13th floor
Radiology
Viking Room, 13th floor
Chest Diseases
Mandarin Room, 13th floor
Auxiliary Business Session
Solarium, Lounge floor
12:00 noon—House of Delegates (election)
Viking Room, 13th floor
1:00 p. m.—Luncheons:
Auxiliary
Rutland Room, 1st floor
New Jersey Medical Women's Association
Benjamin West Room, 13th floor
Joint Committee on Professional Relations
Room 1333, 13th floor
New Jersey Society of Chest Physicians
Bakewell Room, 1st floor
2:00 p. m.—General Session
Viking Room, 13th floor
3:00 p. m.—Auxiliary Business Session (con't.)
Solarium, Lounge floor
4:15 p. m.—New Jersey Rheumatism Association
Mandarin Room, 13th floor
6:15 p. m.—Social
Rutland Room, 1st floor
7:30 p. m.—Dinner-Dance
Carolina Room, Chalfonte Hotel

THURSDAY, APRIL 29, 1948

8:00 a. m.—Auxiliary President's Breakfast
Bakewell Room, 1st floor
10:00 a. m.—Scientific Sections:
Venereal Disease Control
Benjamin West Room, 13th floor
Diseases of Metabolism
Viking Room, 13th floor
Anesthesiology
Mandarin Room, 13th floor
Orthopedics
Tower Room, 13th floor

Auxiliary Executive Board.
Solarium, Lounge floor
12:30 p. m.—Luncheon, New Jersey Orthopedic Society
Bakewell Room, 1st floor
1:30 p. m.—House of Delegates
Viking Room, 13th floor

GENERAL SESSION

WEDNESDAY AFTERNOON, APRIL 28, 1948

Viking Room, 13th Floor

2:00 p. m.

Surgery of Malignant Disease of the Larynx and Pharynx

Henry B. Orton, M.D., Newark
Professor, Laryngeal Surgery, New York Polyclinic Hospital.

2:50 p. m.

Implications of Socialized Medicine

Arthur L. Conrad, Chicago
Associate Administrator, National Physicians Committee for Extension of Medical Service.

3:10 p. m.

Medicine Is Global

I. Snapper, M.D., New York City
Physician to Mt. Sinai Hospital and Director of Medical Education; Clinical Professor of Medicine, Columbia University.

SECTION MEETINGS

Tuesday Morning, April 27, 1948

PEDIATRICS

ROBERT E. JENNINGS, M.D., Chairman
ISRAEL J. WOLF, M.D., Secretary

Viking Room, 13th Floor

10:00 a. m.

Interrelation of Orthodontia and Pediatrics

Walter M. Dunlap, D.D.S., East Orange, Member, Northeast Orthodontia Society, American Society of Orthodontia.
Discussors: Harlan S. DeVoe, D.D.S., Maplewood
Lyndon A. Peer, M.D., Newark

10:30 a. m.

Management of the Child with Hay Fever or Asthma

William B. Nevius, M.D., East Orange, Assistant Attending Pediatrician, Orange Memorial Hospital.
Discussor: Nathan Schaffer, M.D., East Orange

11:00 a. m.

Management of Surgical Emergencies in the Newborn

Bruce M. Hogg, M.D., New York City, Instructor in Surgery, College of Physicians and Surgeons, Columbia University.
Discussor: Charles Evans, M.D., East Orange

11:30 a. m.

Business Session

EYE, EAR, NOSE AND THROAT

JOHN P. BRENNAN, M.D., Chairman
ALBERTOS M. K. MALDEIS, M.D., Secretary

Mandarin Room, 13th Floor

10:00 a. m.

Congenital Abnormalities of the Upper Respiratory Tract

George R. Brighton, M.D., New York City, Associate Clinical Professor of Otolaryngology, College of Physicians and Surgeons, Columbia University.
Discussors: Oram R. Kline, M.D., Camden
Edgar P. Cardwell, M.D., Newark

10:40 a. m.

Practical Points Regarding Glaucomatous Surgery

James S. Shipman, M.D., Camden, Clinical Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania.
Discussors: Elbert S. Sherman, M.D., Newark
Irvin Levy, M.D., Trenton

11:20 a. m.

General Discussion

11:40 a. m.

Business Session

MEDICINE

CHARLES D. DRISCOLL, M.D., Chairman
JOHN H. ROWLAND, M.D., Secretary

Rutland Room, 1st Floor

10:00 a. m.

Electrocardiogram in the Diagnosis of Coronary Artery Disease

Simon Dack, M.D., New York City, Adjunct Physician in Cardiology, Mt. Sinai Hospital.
Discussors: Estelle E. Kleiber, M.D., New Brunswick
Walter A. Crist, M.D., West Collingswood

10:45 a. m.

Functional Changes in Blood Platelets in Relation to Thrombo-Embolism

Sylvan E. Moolten, M.D., Highland Park, Director of Laboratories, St. Peter's General Hospital and Middlesex General Hospital, New Brunswick.
Discussor: Jerome G. Kaufman, M.D., Newark

11:20 a. m.

Business Session

11:25 a. m.

Non-Specific Treatment of Allergic Diseases

Harry L. Rogers, M.D., Riverton, Chief, Allergy Clinic, Jefferson Hospital, Philadelphia.
Discussor: Nathan Swern, M.D., Trenton

Tuesday Afternoon, April 27, 1948

NEUROPSYCHIATRY

HENRY A. COTTON, JR., M.D., Chairman
HARRISON F. ENGLISH, M.D., Secretary

Viking Room, 13th Floor

2:00 p. m.

Treatment of Psychosomatic Illness
O. Spurgeon English, M.D., Philadelphia, Professor of Psychiatry, Temple University School of Medicine.

Discussors: Theodore R. Robie, M.D., East Orange
David J. Flicker, M.D., Newark

2:40 p. m.

Group Psychotherapy in Private Practice
Lewis H. Loeser, M.D., Newark, Attending Neurologist, Presbyterian Hospital.

Discussors: Henry A. Davidson, M.D., Flemington
Edward N. Pleasants, M.D., Marlboro

3:20 p. m.

Effect of Neurosurgical Procedures on Certain Psychiatric Disorders
Archie Crandell, M.D., Greystone Park, Assistant Clinical Director, New Jersey State Hospital at Greystone Park.

Discussors: Thomas S. P. Fitch, M.D., Plainfield
Laurence M. Collins, M.D., Greystone Park

SURGERY

Clymont MacArthur, M.D., Chairman
SAMUEL J. LLOYD, M.D., Secretary

Rutland Room, 1st Floor

2:00 p. m.

Management of Large Bowel Malignancy
Richard B. Cattell, M.D., Boston, Surgeon, Lahey Clinic, New England Baptist Hospital; Surgeon-in-Chief, New England Deaconess Hospital.

Discussor: Harry N. Comando, M.D., Newark

2:45 p. m.

Gall Bladder Disease
Victor B. Seidler, M.D., Montclair, Senior Surgeon, Mountainside Hospital.

Discussors: Surgical Aspect
Edwin R. Ristine, M.D., Westville
Medical Aspect
Harvey M. Ewing, M.D., Montclair

3:25 p. m.

Anti-Coagulant Treatment of Venous Thrombosis
Arthur J. D'Alessandro, M.D., Newark, Associate Surgeon, St. James Hospital.

Discussor: George L. Erdman, M.D., Irvington

OBSTETRICS AND GYNECOLOGY

RAYMOND T. POTTER, M.D., Chairman
JOSEPH P. DONNELLY, M.D., Secretary

Benjamin West Room, 13th Floor

2:00 p. m.

Hysterectomy: A Summary of Over 2000 Cases
Albert S. Harden, M.D., Newark, Visiting Surgeon, Newark City Hospital.

(Co-Author: Salvatore J. Rose, M.D., Orange, Pathologist, St. Michael's Hospital, Newark)

Discussor: Hammell P. Shipps, M.D., Camden

2:45 p. m.

General Discussion

3:00 p. m.

Surgical Complications of Pregnancy
J. Robert Willson, M.D., Philadelphia, Professor and Head of Department of Obstetrics and Gynecology, Temple University School of Medicine.

Discussor: Edward G. Waters, M.D., Jersey City

3:45 p. m.

General Discussion

GASTRO-ENTEROLOGY AND PROCTOLOGY

SIGURD W. JOHNSEN, M.D., Chairman
THEODORE S. HEINEKEN, M.D., Secretary

Mandarin Room, 13th Floor

2:00 p. m.

Diagnosis and Treatment of Ulcerative Colitis
Johannes F. Pessel, M.D., Trenton, Assistant Professor of Gastro-Enterology, Graduate School of Medicine, University of Pennsylvania.

Discussors: Manfred Kraemer, M.D., Newark
Julius Gerendasy, M.D., Elizabeth

2:40 p. m.

Symptomatology of Gastric Cancer
George T. Pack, M.D., New York, Professor of Surgery, New York Medical College.
(Co-Authors: John S. LaDue, M.D., and Paul Murison, M.D., New York)

Discussors: Reuben L. Sharp, M.D., Camden
Perry J. Culver, M.D., West Roxbury, Mass.

3:20 p. m.

Hepatitis
Max Magnes, M.D., Paterson, Consulting Physician in Gastro-Enterology, Barnert Memorial Hospital.

Discussors: Andrew J. V. Klein, M.D., Newark
S. William Kalb, M.D., Newark

Wednesday Morning, April 28, 1948

CHEST DISEASES

JOHN E. RUNNELLS, M.D., Chairman
HOMER H. CHERRY, M.D., Secretary

Mandarin Room, 13th Floor

9:30 a. m.

Streptomycin in the Treatment of Tuberculosis
Carl Muschenheim, M.D., New York City, Associate Professor of Clinical Medicine, Cornell University Medical College.
Discussor: Samuel Cohen, M.D., Jersey City

10:05 a. m.

Non-Tuberculous Infections Complicating Pulmonary Tuberculosis
Otto S. Baum, M.D., South Orange, Attending Physician in Medicine, St. Mary's Hospital, Orange.
Lewis F. Baum, M.D., South Orange, Assistant in Medicine, College of Physicians and Surgeons, Columbia University.
Discussor: Irving Willner, M.D., Newark

10:40 a. m.

Aerosol Antibiotic Therapy in Suppurative Diseases of the Lungs and Bronchi
Benjamin P. Potter, M.D., Jersey City, Chief, First Division, B. S. Pollak Hospital for Chest Diseases.
Discussor: Paul K. Bornstein, M.D., Asbury Park

RADIOLOGY

HARRY R. BRINDLE, M.D., Chairman
RAPHAEL POMERANZ, M.D., Secretary

Viking Room, 13th Floor

9:30 a. m.

Radioactive Isotopes in Medicine
Richard H. Chamberlain, M.D., Philadelphia, Associate in Radiology, Graduate School of Medicine, University of Pensylvania.
Discussor: Milton Friedman, M.D., Newark

10:25 a. m.

Myelography with Pantopaque
Frank P. Carrigan, M.D., Newark, Attending Roentgenologist, St. Michael's Hospital.
Discussor: Benjamin Copleman, M.D., Perth Amboy

11:05 a. m.

Roentgenologic Evaluation of Abdominal Pathology
Raphael Pomeranz, M.D., Newark, Attending Roentgenologist, Crippled Children's Hospital.

CLINICAL PATHOLOGY

ASHER YAGUDA, M.D., Chairman
WILLIAM W. HERSOHN, M.D., Secretary

Tower Room, 13th Floor

9:30 a. m.

Liver Functional Tests
Frank W. Konzelmann, M.D., Absecon, Pathologist, Atlantic City Hospital.

9:50 a. m.

Hodgkin's Disease—Its Relation to the Other Neoplasms of Lymphatic Tissue
William G. Bernhard, M. D., Summit, Pathologist, Overlook Hospital.
(Co-Author: R. P. Custer, M.D., Philadelphia, Pathologist, Presbyterian Hospital)
Discussor: John L. Work, M.D., Montclair

10:15 a. m.

Beryllium Poisoning
Harrison S. Martland, M.D., Newark, Chief Medical Examiner, Essex County; Professor, Forensic Medicine, New York University.
Discussor: Harrison S. Martland, Jr., M.D., New York City

10:50 a. m.

Protective Measures in Handling Radioactive Isotopes
F. William Sunderman, M.D., Philadelphia, Professor of Clinical Pathology, Director, Laboratory of Clinical Medicine, Temple University School of Medicine.

Thursday Morning, April 29, 1948

DISEASES OF METABOLISM

GEORGE GINSBERG, M.D., Chairman
LEONARD D. WILLIAMS, M.D., Secretary

Viking Room, 13th Floor

10:00 a. m.

Vascular Complications of Diabetes Mellitus
Gerald H. Pratt, M.D., New York City, Assistant Professor of Surgery, New York Post Graduate Hospital and Medical School, Columbia University.
Discussors: George M. Knowles, M.D., Hackensack
Stuart Z. Hawkes, M.D., Newark

10:40 a. m.

Early Diagnosis of Diabetes Mellitus
Jacob C. Fineberg, M.D., Jersey City, Attending Physician, Medical Service, Medical Center.

Discussors: William A. Nyiri, M.D., Newark
Norman L. Murray, M.D., Summit

11:20 a. m.

Dietary Management of Diabetes Mellitus
Selma Weiss, M.D., Newark, Attending Physician on Metabolism, Newark City Hospital.

Discussors: Benjamin Saslow, M.D., Newark
Everett O. Bauman, M.D., Newark

ORTHOPEDICS

TOUFICK NICOLA, M.D., Chairman
NICHOLAS RANSOHOFF, M.D., Secretary

Tower Room, 13th Floor

10:00 a. m.

Conservative Treatment of Low-Back Pain
John J. Flanagan, M.D., Newark, Attending Orthopedic Surgeon, St. Michael's Hospital and Presbyterian Hospital.

10:20 a. m.

Operative Aspect of Low-Back Pain
Henry Briggs, M.D., East Orange, Attending Orthopedic Surgeon, New Jersey Orthopedic Hospital, Orange, and East Orange General Hospital.

10:40 a. m.

Medico-Legal Aspects of Low-Back Pain
Henry H. Kessler, M.D., Newark, Attending Orthopedic Surgeon, Hospital and Home for Crippled Children and Newark City Hospital.

11:00 a. m.

General Discussion

ANESTHESIOLOGY

HAROLD G. WALKER, M.D., Chairman
EDWARD T. LAWLESS, M.D., Secretary

Mandarin Room, 13th Floor

10:00 a. m.

Selection of Anesthesia for the Patient with Medical Complications
Henry S. Ruth, M.D., Haverford, Pa., Professor of Anesthesiology, Hahnemann Medical College, Philadelphia.

Discussors: Leo J. Fitzpatrick, M.D., West Englewood
Karl S. Russell, M.D., Collingswood

11:00 a. m.

Spinal Anesthesia in Obstetrics
Irving Hayman, M.D., Paterson, Director of Anesthesia, Lincoln Hospital, New York.
Discussors: Abraham L. Dear, M.D., Newark
Anthony P. Vernaglia, M.D., Hawthorne

VENEREAL DISEASE CONTROL

ROBERT L. MCKIERNAN, M.D., Chairman
ISIDORE PINCUS, M.D., Secretary

Benjamin West Room, 13th Floor

10:00 a. m.

Venereal Disease Among Juvenile Delinquents
Norman R. Ingraham, Jr., M.D., Philadelphia, Chief, Division of Venereal Disease Control, Philadelphia Department of Public Health.

10:40 a. m.

General Discussion

11:00 a. m.

Modern Venereal Disease Problem and Its Sex Education Front
John H. Stokes, M.D., Philadelphia, Director, Institute for the Control of Syphilis, University of Pennsylvania; Professor of Dermatology-Syphilology, Graduate School of Medicine, University of Pennsylvania.

11:40 a. m.

General Discussion

DINNER DANCE

in honor of PRESIDENT AND MRS. ROYAL A. SCHAAF

Wednesday, April 28, 1948

7:30 p. m.

Carolina Room, Chalfonte Hotel

Toastmaster: Dr. Chester I. Ulmer
Welcome: Mrs. Lodovico Mancusi-Ungaro, President, Woman's Auxiliary
Dr. Royal A. Schaaf, President

Introductions: Mrs. Robert B. Walker, President-Elect, Woman's Auxiliary
Dr. J. Howard Hornberger, President-Elect

Presentation of Fellow's Key:
To: Dr. Royal A. Schaaf, President
By: Dr. Samuel Alexander, Fellow

Guest Speaker: Dr. John C. Krantz, Jr., Professor of Pharmacology, University of Maryland
"The Simplicity to Wonder"

Choral Singing: Male Chorus of the Essex County Medical Society

CONFERENCE OF THE NEW JERSEY PLAN FOR IMPROVEMENT OF SCHOOL HEALTH SERVICES

TUESDAY, APRIL 27, 1948

Viking Room, 13th Floor

4:15 p. m.

Presiding—Harold F. Tidwell, M.D., Chairman, Consulting Committee to the School Health Program

Background of the New Jersey Plan
Samuel Blaugrund, M.D., Chairman, Public Health Committee

The Function of the School Physician—Importance of Standardization of Services

The Role of the Department of Education in the School Health Program
John H. Bosshart, Commissioner, New Jersey State Department of Education

Progress Report on the Implementation of the New Jersey Plan by the Woman's Auxiliary
Mrs. Asher Yaguda, Chairman, Public Relations Committee, Woman's Auxiliary

General Discussion

Summary—Dr. Tidwell

HOUSE OF DELEGATES

Presiding Officer, Royal A. Schaaf, M.D., President, Newark
Secretary, Earl L. Wood, M.D., Newark

The Committee on Credentials will meet at the Registration Desk each morning of the meeting

Viking Room, 13th Floor

First Session: 2:00 p. m., Monday, April 26, 1948

Order of Business

a. Call to Order
b. Organization of House of Delegates
c. Minutes of 1947 Meeting
d. Introduction of Delegates from Other States
e. Annual and Supplemental Reports
f. Award to Outstanding General Practitioner
g. Announcements

Second Session: 12:30 p.m., Wednesday, April 28, 1948

Order of Business

a. Report of Nominating Committee
b. Election

Third Session: 1:30 p. m., Thursday, April 29, 1948

Order of Business

a. Reports of Reference Committees
b. Unfinished Business
c. Installation of Incoming President
d. Adjournment

REFERENCE COMMITTEES

Tuesday Evening, April 27, 1948, 8:30 P. M.
13th Floor

Reference Committee "A", to consider reports of:
The President
The Board of Trustees
The Secretary
The Judicial Council
The Executive Officer

Reference Committee "B", to consider reports of:
The Treasurer
The Finance and Budget Committee
The Publication Committee

Reference Committee "C", to consider reports of:
The Medical Service Administration
The Medical-Surgical Plan
The Committee on Study of Medical Care
The Veterans Liaison Committee
The Military Service Committee

Reference Committee "D", to consider reports of:
The Post-Graduate Education Committee
The Scientific Work Committee
The Medical Defense and Insurance Committee
The Advisory Committee to the Woman's Auxiliary
The State Board of Medical Examiners

Reference Committee "E", to consider reports of:
The Welfare Committee
The Subcommittees of the Welfare Committee
The Advisory Committees to the Subcommittees of the Welfare Committee
The New Jersey Health Congress

Reference Committee on Constitution and By-Laws.

Reference Committee on Miscellaneous Business, to consider also reports of:
The Annual Meeting Committee
The Subcommittee on Scientific Program
The Subcommittee on Scientific Exhibits

Reference Committee on Resolutions and Memorials, to consider also report of:
The Committee on Honorary Membership

Reference Committee on Credentials
Meets at Registration Desk each morning of the meeting.

MOTION PICTURE THEATRE

Lounge Floor

Films will be shown daily. The schedules will be posted at the Scientific Exhibit.

1. Rehabilitation of the Amputee.
2. The Shoulder-Hand Syndrome.
3. Substitute Transfusions in Erythroblastosis Fetalis.
4. Scables.
5. Surgical Treatment of Cancer of the Rectum.
6. Animated Hematology.
7. Diagnostic Procedures in Tuberculosis.
8. Surgery in Chest Diseases.
9. A New Horizon.
10. Management of the Failing Heart.

SPECIAL EVENTS

MONDAY, APRIL 26, 1948

6:30 p. m.—Fellows' Dinner
Rowsley Room, 1st floor

TUESDAY, APRIL 27, 1948

3:30 p. m.—Auxiliary Tea
Solarium, Lounge floor

4:15 p. m.—Conference on School Health
Viking Room, 13th floor

6:30 p. m.—Fellowettes' Dinner (by invitation only)

WEDNESDAY, APRIL 28, 1948

1:00 p. m.—Luncheons:
Auxiliary (fee $4.00)
Rutland Room, 1st floor
Section on Chest Diseases
Bakewell Room, 1st floor

New Jersey Medical Women's Ass'n
Benjamin West Room, 13th floor
Joint Committee on Professional Relations
Room 1333, 13th floor

4:15 p. m.—New Jersey Rheumatism Association
Mandarin Room, 13th floor

6:15 p. m.—Social
Rutland Room, 1st floor

7:30 p. m.—Banquet (fee $6.00)
Carolina Room, Chalfonte Hotel

THURSDAY, APRIL 29, 1948

8:00 a. m.—Auxiliary President's Breakfast
Bakewell Room, 1st floor

12:30 p. m.—Luncheon
New Jersey Orthopedic Society
Bakewell Room, 1st floor

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

TWENTY-FIRST ANNUAL MEETING

PROGRAM

Tuesday, April 27, 1948

10:00 a. m. — Registration — Luncheon and Dinner Tickets
Lounge floor

1:00 p. m.—Pre-Convention Board Meeting
Solarium, Lounge floor

3:30 p. m.—Informal 'get-together' — tea will be served
Solarium, Lounge floor
All physicians' wives cordially invited

4:15 p. m.—School Health Program Conference
Viking Room, 13th floor

6:30 p. m.—Fellowettes' Dinner (by invitation only)

Wednesday, April 28, 1948

9:30 a. m.—General Session
Solarium, Lounge floor
Order of Business:
a. Invocation: Rev. Harvey Bennett, First Presbyterian Church, Atlantic City
b. Greetings: Mrs. Edward H. Dyer, President, Woman's Auxiliary to the Atlantic County Medical Society
c. Response: Mrs. Robert B. Walker, President-Elect
d. Memorial Services for Departed Members: Mrs. John Nevin, Fellowette
e. Reports

1:00 p. m.—Luncheon honoring Mrs. Lodovico Mancusi-Ungaro, President
Rutland Room, 1st floor
Toastmistress: Mrs. Asher Yaguda
Welcome: Mrs. Lodovico Mancusi-Ungaro, President
Greetings: Royal A. Schaaf, M.D., President, The Medical Society of New Jersey
William E. Dodd, M.D., Chairman, Advisory Committee to Woman's Auxiliary
Guest Speaker: William W. Bolton, M.D., Bureau of Health Education, American Medical Association, Chicago
"The Role of the Physician's Wife in Community Health Education"
Presentation of President's Pin:
To: Mrs. Lodovico Mancusi-Ungaro, President
By: Mrs. Frederick G. Wandall, Junior Past-President
Entertainment: Trio

3:00 p. m.—Business Session, continued
Solarium, Lounge floor
Order of Business:
a. Unfinished Business
b. Report of Nominating Committee
c. Election of Officers
d. Inauguration of Incoming President, Mrs. Robert B. Walker
e. Installation of Officers

6:30 p. m.—Social
Rutland Room, 1st floor

7:30 p. m.—Dinner Dance
Carolina Room, Chalfonte Hotel

Thursday, April 29, 1948

8:00 a. m.—President's Breakfast
Bakewell Room, 1st floor

10:00 a. m.—Post Convention Board Meeting
Solarium, Lounge floor

SCIENTIFIC EXHIBITS

Lounge Floor

Booth 1—Roentgen Manifestations of Horner's Syndrome — Raphael Pomeranz, M.D., Newark—Transparencies demonstrating various causes of Horner's Syndrome: congenital, inflammatory traumatic, degenerative and neoplastic lesions. Clinical, radiographic and histologic findings of most of the cases are being presented.

Booth 2 — Occupational Dermatitis — Paul C. Campbell, Jr., M.D., Chief, Dermatology Section, Industrial Hygiene Division, U. S. Public Health Service, Washington, D. C.

Booth 3—Phthalyl Sulfacetimide in Ulcerative Colitis—Theodore S. Heineken, M.D., Bloomfield; Harry Seneca, M.D., Montclair—This is a panel exhibit presenting: (1) general principles, rationale and results of the method of treatments; (2) pharmacology and chemistry of phthalyl sulfacetimide in ulcerative colitis; (3) illustrative clinical cases, with roentgenograms.

Booth 4 — Surface Active Solvents in Topical Anti-Biotic Therapy—E. J. Grace, M.D., V. Bryson, M.D., The Grace Clinic and Biological Laboratory, Brooklyn, N. Y., Cold Spring Harbor, L. I.—Methods and clinical results of the topical administration of penicillin and streptomycin in solutions of reduced surface tension with enhanced penetrative and detergent capacity. Experimental evidence is presented showing that in combination with selected surface active chemicals, the activity of penicillin is synergistically enhanced when tested against both normal and penicillin resistant bacterial strains.

The clinical significance of multiple chemotherapy is considered in relation to the origin of bacterial resistance to penicillin and streptomycin. The advantages of topical application and increased penetrative capacity are exhibited as of fundamental importance in treatment of areas of isolated infection.

Clinical experience in aerosol therapy and other forms of topical administration are reviewed in cases of respiratory disease, including tuberculosis and in general pyogenic infections of soft tissue and bone.

Booth 5—Bone Surgery of the Hand—Spencer T. Snedecor, M.D., Hackensack, N. J. — Lantern slides illustrate basic hand surgery problems in connection with bones, including formation of new thumb bone blocks between first and second metacarpals, apposition of thumb and correction of malunion of phalanges and metacarpals. Bone grafts for nonunion of metacarpals are demonstrated along with slides showing the correction of metacarpal defects involving joint with metatarsal graft.

Booth 6 — Tumors of Childhood — Harold W. Dargeon, M.D., Memorial Hospital, New York, N. Y. —The tumors frequently encountered during childhood occur in sites other than those usually involved in the adult. While some are highly malignant, cures of many types are known. The exhibit shows the more common clinical evidences of different varieties of children's neoplasms. Charts illustrating the importance of tumors as a child health problem are also included.

Booth 7—Foreign Bodies in the Air and Food Passages—Chevalier L. Jackson, M.D.; Charles M. Norris, M.D.; Walter H. Maloney, M.D., Temple University Hospital and School of Medicine, Philadelphia, Penna.—An outline of the history of bronchoscopy and esophagoscopy is presented. Salient features of diseases of foreign body origin are exhibited from the point of view of etiology, symptomatology, diagnosis, pathology and treatment. Also shown is the mechanism of bronchial obstruction by foreign bodies and the importance of its manifestation by physical signs and x-ray examination. Bronchoscopy in the diagnosis of diseases of other than foreign body origin is demonstrated. Additional specimens of foreign bodies are displayed and interesting facts regarding the histories of typical cases are given, including an explanation of the mechanical problems presented and methods of their solution.

Booth 8—Brucellosis — Harold Harris, M.D., New York, N. Y.,Edwin H. Albano, M.D., East Orange, N. J.—This exhibit consists of posters showing the etiology, epidemiology, symptomatology, diagnosis and treatment of brucellosis; transparencies of skin manifestations and skin testing; opsono-phagocytic indices, etc.; x-rays of the bone in brucellosis and microscopic demonstration of various degrees of opsono-phagocytic activity following treatment.

Booth 9—The Rh Factor in Erythroblastosis—Philip Levine, M.D., Ortho Research Foundation, Raritan, N. J.—A series of charts and photographs giving the history of the Rh factor, statistical proof for the pathologic genesis of erythroblastosis, racial tendencies, mechanism of transplacental iso-immunization, varieties of anti-Rh sera, heredity of the Rh - Hr systems in the role of the anamnestic reaction in the occurrence of erythroblastosis in the first born. The exhibit has been planned to be useful for the general practitioner as well as to the obstetrician and clinical pathologist.

Booth 10 — Primary and Secondary Sprue—Clinical and Pathological Studies—David Adlersburg, M.D., Joseph Schein, M.D., Mt. Sinai Hospital, New York, N. Y.—This exhibit highlights the pathologic changes in primary sprue, consisting of hyaline band formation in the villi of the small intestine, trabeculation of the mesenteric glands, deposition of pigment in the muscularis mucosae of the small intestine and varying degrees of pancreatic fibrosis. Also shown is secondary sprue with gross involvement of the small intestine and/or mesenteric glands, (lymphosarcoma). amyloidosis and intestinal lipodystrophy.

Booth 11—Osteophies Encountered in the Endocrine Clinic—Rita S. Finkler, M.D.; George M. Cohn, M.D.; N. James Furst, M.D., Beth Israel Hospital, Newark, N. J.—The group consists of thyro-pituitary dysfunction, Turner's Syndrome, Lorain-Levi dwarfism, hypogenitalism with polyostotic fibrous dysplasia, pseudo-Froehlich's Syndrome with osteogenesis imperfecta, pituitary adenoma with acromegalic manifestations and macrosomia genitalis with accelerated bony maturation.

The presentation consists of "before and after" photographs of the patient, x-rays at various periods of treatment, laboratory findings, synopses of clinical findings and discussion. These cases have been grouped together because they demonstrate a common denominator of osseous change.

Booth 12—Studies on Blood Platelets in Health and Disease — Sylvan E. Moolten, M.D.; Leo Vroman, St. Peter's General Hospital, New Brunswick, N. J.—Here are exhibited charts and experimental and clinical data bearing on the role of platelets in disorders of hemostasis, with special reference to thrombosis and hemorrhagic diatheses. Photographs include colored drawings and graphs illustrating changes in platelets under conditions leading to increased stickiness and clumping, followed by thrombosis; likewise effects of various anti-coagulants, including dicumarol and heparin. Other exhibits illustrate phases of platelet function in thrombocytopenic purpura, pseudo-heomophilia and heomophilia. On display is a model of the apparatus used in a new test for platelet stickiness (the Filter Test) and representative curves are presented from actual cases showing the relationship between platelet changes and subsequent development of thrombosis or hemorrhage in the living patient, including the effects of dicumarol and heparin.

Booth 13 — Testis Tumors — Milton Freedman, M.D.; Lloyd G. Lewis, M.D., Lutheran Memorial Hospital, Newark, N. J.—The exhibit consists of charts, photographs, x-rays and photo-micrographs of specimens of a series of 250 testes tumors. The subjects illustrated include pathology, classification, surgical and radiation treatment, complications and hormone assays.

Booth 14—Needle Biopsy of Liver—Thomas J. White, M.D., Carroll M. Leevy, M.D., Angelo M. Gnassi, M.D., H. Preston Price, M.D., Jersey City Medical Center, Jersey City, N. J.—The exhibit consists of (1) posters showing the indications, contra-indications and preparations necessary for needle biopsy; (2) posters showing the correlation and dissociation of needle biopsy and liver function studies; (3) moulages illustrating the technic of needle biopsy; (4) illustrative photographs and micrographs with case histories and liver function studies; and (5) representative biopsy specimens under microscope.

Booth 15—The Shoulder-Hand Syndrome—Reflex Dystrophy, Diagnosis and Treatment—Otto Steinbrocker, M.D., Richard Marton, M.D., Bellevue Hospital, Fourth Medical Division, New York University, New York, N. Y.—This pictorial review of the syndrome in its various stages is supplemented by outlines of diagnostic features and etiology. A brief summary and short illustration of the postulated underlying mechanism is presented. Outlines of therapeutic methods are included, with drawings and illustrations of the treatment of choice—(stellate ganglion block) together with an analysis of immediate results and follow up.

Booth 16—The Use of Anti-Biotics in Chronic Pulmonary Diseases—Benjamin P. Potter, M.D., Samuel Cohen, M.D., B. S. Pollak Hospital for Chest Diseases, Jersey City, N. J.—Cases are shown illustrating indications and results with anti-biotics in chronic pulmonary diseases, especially pulmonary abscess, bronchiectasis and tuberculosis. The technic of aerosol therapy is described and demonstrated.

Booth 17—Rutin Therapy in Hypertension—J. Q. Griffith, Jr., M.D., R. L. Shanno, M.D., J. F. Couch, M.D., Philadelphia, Penna.—This exhibit spotlights a study of 525 persons with hypertension associated with either increased capillary fragility, increased cutaneous lymphatic flow, or both; 450 of these have been followed for from 3 months to 4 years. Compared with a control group, in whom both tests were normal, the incidence of apoplexy, retinal hemorrhage and death has been studied—the first two before, and in certain cases, after rutin therapy. It was found that the incidence of these complications was higher in the abnormal group, but after successful rutin therapy, these improved so as to be about equal to the control group.

Booth 18 — Rehabilitation of the Amputee—Henry H. Kessler, M.D., Hasbrouck Heights Hospital, Hasbrouck Heights, N. J.—The exhibit consists of photographs, examples of artificial limbs and live amputees. Emphasized is the five point program of rehabilitating amputees by psychology, surgery, after-care of stump, proper selection of prosthesis and training.

Booth 19—Unipolar Electrocardiography: The Theory of Directions of Currents—C. E. Kiessling, M.D., A. M. Lyle, M.D., H. B. Kirkland, M.D., The Prudential Insurance Co., Newark, N. J.—Charts and diagrams are presented relating the flow and direction of currents associated with cardiac activity to the form of the electrocardiogram in the normal and abnormal subject. Practical aspects of unipolar extremity and precordial electrocardiograms are discussed. Detailed descriptions of tracings showing ventricular hypertrophy, conductive defects and infarcts are given, illustrations being correlated with theoretical considerations.

Booth 20—Plastic Surgery — Lyndon A. Peer, M.D., Newark, N. J.—A motion picture will be shown in the booth demonstrating the practical use of skin grafts in general surgery, as well as the technic for total external ear reconstruction. The exhibit includes photographs and drawings, demonstrating various types of reconstructive plastic surgery.

Booth 21—Treatment of Fractures of the Leg—New Jersey Orthopedic Society—Through the use of x-rays, line drawings, splints, traction methods and plaster casts, treatments of fractures of the leg ankle and foot will be outlined, with emphasis on conservative methods. Indications for operative intervention will be detailed. The various types of injury will be dealt with serially, the program changed each morning and afternoon during the meeting.

Booth 22—Jaundice—Andrew J. V. Klein, M.D., St. Barnabas Hospital, Newark, N. J.—Jaundice is classified into medical and surgical types. These types are described regarding differentiation between medical and surgical jaundice, the physiology of each and the proper treatment.

Booth 23—Endocrine Factors in Vascular Disease — Benjamin Jablons, M.D., A. H. Wolfson, M.D., Otis M. Cope, M.D., Norman Pomerantz, M.D., Goldwater Memorial Hospital, New York Polyclinic Hospital, New York Medical College, New York, N. Y.—Renal insufficiency is outlined with and without adrenal corticoids in the production of vascular disease. The effect of tubuline (renal extract) and anti-thyroid drugs, testosterone and electrolytes

on this process and on clinical arteriosclerosis obliterans is presented.

Booth 24—Sudden Death in Infancy—Thymico-Adrenal Syndrome — Harrold A. Murray, M.D., Salvatore J. Rose, M.D., St. Michael's Hospital, Newark, N. J.—Charts and posters summarize the symptoms, signs and treatment of thymico-adrenal syndrome. Photographs of gross specimens from post-mortem cases are displayed.

Booth 25 — Histogenesis of Hydatiform Mole and Chorionepithelioma—Nicholas M. Alter, M.D., Margaret Hague Maternity Hospital, Jersey City, N. J.—This is the visual expression of morphologic research in an attempt to define true mole versus false mole. A discussion of benign and malignant mole is presented. The exhibit also traces the development from trophoblast to carcinoma.

Booth 26—Substitution Transfusion Treatment of Erythroblastosis Fetalis — Harry Wallerstein, M.D., Jewish Memorial Hospital, New York, N. Y.—Kodachrome enlargements demonstrate the pathology believed responsible for failure of former methods of therapy. Charts depict the older therapeutic regimes and compare the results with those after substitution therapy. Significant case reports are illustrated. The methods of substitution (sagittal sinus, radial artery and umbilical vein technics) are described and illustrated by kodachrome enlargements. The criteria for substitution therapy are given. The efficiency of the various methods are compared mathematically by plotted curves. There is also a manikin on which the three technics are demonstrated. A colored moving picture (shown in the motion picture theatre) demonstrates the procedures in actual use.

Booth 27—Chronic Sinobronchitis in Children—Carl G. Hanson, M.D., Cranford, N. J.—The treatment of 35 cases of chronic sinobronchitis in children is presented. These cases are from the exhibitor's office practice. They are grouped according to treatment indicated and x-rays before and after treatment are shown. Bacterial cultures before and after treatment are tabulated. Clinical results are indicated by clinical impressions as well as a "disability diary" kept one year before and one year after treatment. Aerosol anti-biotics, used in some cases are demonstrated.

EDUCATIONAL EXHIBITS

Lounge Floor

Booth 28—Public Relations Is Public Service—Subcommittee on Public Relations, The Medical Society of New Jersey, Trenton, N. J.—Methods by which The Medical Society of New Jersey activates its programs of service and health education are portrayed. A graphic display shows the media used in carrying organized medicine's message to the public in New Jersey. Samples of literature used or distributed by the Society are available.

Booth 29—Prescription for Good Eye Care—Guild of Prescription Opticians of New Jersey, Inc., Newark, N. J.

Booth 30—Rheumatic Fever and Rheumatic Heart Disease—Children's Heart Unit of the Victoria Foundation, Inc., Morris Plains, N. J.—The exhibit consists of posters giving criteria for diagnosis and activity; graphs showing effects of sulfonamide prophylactic treatment, dioramas suggesting program of physical limitations in relation to clinical findings of the patients; and photographs of recreational activities employed to achieve physical limitations while maintaining good mental attitude.

Booth 31—The School Child: Health Program and Needs—Donald B. Armstrong, M.D.; George M. Wheatley, M.D., Metropolitan Life Insurance Company, New York, N. Y.—A series of 12 charts describes the conquest of infant and childhood diseases; evidence is displayed of improvement in physical status in children. The current picture of child health is revealed by mortality and morbidity charts, and by the incidence of defects by region and race. Suggestions are given for implementing these principles to advance child health in the future.

Booth 32—Nutrition—S. William Kalb, M.D., Chairman, Advisory Committee on Nutrition, The Medical Society of New Jersey, Newark, N. J.—This is a display of foods and drugs used in nutrition. A dark room for vitamin A testing is shown. There is a demonstration on the use of skim milk and a display on margarine.

Booth 33—A Working Partnership—Division of Health Education, New Jersey State Department of Health, Trenton, N. J.—The high level of health in New Jersey has been achieved in a large part through the working relationship of physicians and health officials. Illustrated here are the new phases of the long standing partnership.

Booth 34—New Jersey Rehabilitation Commission, Trenton, N. J.—This series of posters calls attention to the services provided by the New Jersey Rehabilitation Commission for the physically handicapped.

Booth 35—Implementation of the New Jersey Plan for Improvement of School Health Services—Woman's Auxiliary to The Medical Society of New Jersey Public Relations Committee, Mrs. Asher Yaguda, Chairman; Mrs. Daniel C. Reyner, Co-Chairman.

Booth 36—Diabetes as a Public Health Menace, N. J. Diabetes Association, Newark, N. J.—This exhibit shows the incidence of diabetes, past, present and predicted; hereditary possibilities; earliest symptoms; suggested and tried methods of prevention by the community and by the individual physician; and the results of uncontrolled or undiscovered incidence.

Booth 37—Joint Committee on Professional Relations, Trenton, N. J.—This display of *New Jersey Formulary* prescriptions includes new preparations developed at Rutgers University College of Pharmacy through research supported jointly by The Medical Society of New Jersey and the New Jersey Pharmaceutical Association.

Booth 38—Muscle Testing, National Foundation for Infantile Paralysis, New York, N. Y., Mr. W. C. Bowen, New Jersey Representative—On this exhibit is shown statistical evidence, facts and figures on the number of orthopedically handicapped children in the United States, the proportion caused by poliomyelitis and the five other leading crippling diseases and the comparative age distribution from 1916 to 1944. The four muscles most frequently involved are represented by three dimensional forms and the technics of musle testing are given. Also displayed are maps showing the 1941 to 1947 incidence of polio throughout the nation.

Booth 39—Care and Treatment of Patients with Mental Disease, New Jersey State Hospital, Trenton, N. J.—Pictures and charts display hospital activities and activities at Dorothea Dix Hospital, with colored movies of shock therapy and other forms of treatment.

Booth 40—Care and Treatment of Patients with Mental Diseases, New Jersey State Hospital, Marlboro, N. J., Greystone Park, N. J.

TECHNICAL EXHIBITS

Lounge Floor

Booth 1—Eli Lilly and Company, Indianapolis, Ind.—The Lilly exhibit for 1948 features a presentation of *Dolophine Hydrochloride (Methadon Hydrochloride, Lilly)*. You will be interested in the comparison of postoperative relief of pain with *Dolophine Hydrochloride,* 10 mg. and Morphine, 15 mg. Many other Lilly products will be on display. Attending Lilly medical service representatives will be present to aid visiting physicians in every way possible.

Booth 2—Buffington's, Inc., Worcester, Mass.—Representatives will be present to discuss a number of specialty products which are being actively promoted at this time. Such products as *Hemo-Vitonin, Pillett Diatraegus* and *C. T. Trichonal* will be featured.

Booth 3—Doho Chemical Corporation, New York, N. Y.—The makers of *Auralgan* are introducing at this meeting, their new sulfa drug preparation, *Otosmosan,* indicated in the treatment and control of chronic suppurative ears. Also, Mallon, division of Doho, will display our new liquid topical anesthesia, *Rectalgan,* for relief of pain and itching in hemorrhoids and pruritis. *Rectalgan* enjoys many advantages over the outmoded rectal suppositories and ointments.

Our representatives will be happy to explain, in detail, the workings of these medications.

Booth 4—E. and W. Blanksteen, Jersey City, N. J.—During 1947 many hundreds more of the members of The Medical Society of New Jersey joined the State Society's plan of accident and health insurance underwritten by the National Casualty Company through E. and W. Blanksteen, the officially authorized accident and health insurance agents of the State Society. Another "open season" enrollment has just been completed, permitting increases of coverage to $400 monthly benefit to insurable risks and providing policies as well for doctors who are impaired and were normally unacceptable risks to insurance companies. Members who have not yet joined may obtain full particulars at our exhibit.

Booth 5—Faulhaber & Heard, Inc., Newark, N. J.—TWENTY-SIX YEARS of continuous service to the members of The Medical Society of New Jersey is evidence of the value of our Professional Liability Protection. Information on this very essential coverage is available upon inquiry to us, the Offical Broker of The Medical Society of New Jersey.

Booth 6—Lea & Febiger, Philadelphia, Penna.—This exhibit is of particular interest because of such outstanding new books and new editions as Frohman—*Brief Psychotherapy;* Ormsby and Montgomery—*Diseases of the Skin;* Thienes and Haley—*Clinical Toxicology;* Goldberger—*Unipolar Lead Electrocardiography;* Stimson—*Common Contagious Diseases;* Burch and Reaser—*Primer of Cardiology;* and others, including such leading standard works as Joslin—*Treatment of Diabetes Mellitus;* Musser—*Internal Medicine;* Levinson and MacFate—*Clinical Laboratory Diagnosis* and Wintrobe—*Clinical Hematology.* Our representative will be glad to help you with your individual book problems.

Booth 7—E. R. Squibb & Sons, New York, N. Y.—Presenting a wide variety of newly released preparations for prescription use, among them *Liafon,* a new hematinic, *Pneumococcus Polysaccharides* for Active Immunization, *Penicillin Soluble Troches* 5000 Units, P.O.W. Fluid, *Amniotin Suppositories* (capsule type) and *Diethylstilbestrol* Tablets 25 Mg.

Booth 8—L. & B. Reiner, New York, N. Y.—The *Jones Motor Basal,* original waterless metabolism machine, using a pre-determined volume of oxygen, automatically corrected for barometric pressure and temperature is being exhibited. The exclusive features of self-correcting, double slope tracing and no calculations will be shown.

We are also exhibiting the *EPL Cardiotron,* the first successful direct recording electrocardiograph, with the following exclusive features: Millivolt indicator; time check on the lead; recording jeweled point on permanent paper. No slurring, blurring, flooding, fading or flaking off.

Booth 9 — Hoffmann-LaRoche, Inc., Nutley, N. J.—Members of the Society are invited to visit this booth where members of the representative staff will be present to discuss such NEW products as *Syrup Sedulon,* a sedative cough preparation; *Thephorin,* an antihistamine compound; *Rayopake,* a contrast medium; and other products of interest to physicians.

Booth 10—Hanovia Chemical & Mfg. Company, Newark, N. J.—Ultraviolet equipment of latest design for orificial and body radiation will be on display. Don't fail to ask for a demonstration of the new Wood's black light lamp that has extensive use for diagnostic purposes. New F.C.C. approved short wave unit will be demonstrated daily.

Booth 11 — Nutrition Research Laboratories, Chicago, Ill.—This exhibit will feature *Ertron—Steroid Complex, Whittier*—in both oral and parenteral form, for the treatment of arthritis; *Bezon, Whole Vitamin B Complex with Vitamin C; Infron Pediatric* for rickets prophylaxis; *Pendarvon Granules,* a palatable source of amino acids and vitamins of the B complex.

Booth 12 — The Mennen Company, Newark, N. J.—An exhibit of *Mennen Antiseptic Baby Oil, Baby Powder, Mennen Castile Baby Soap, Tips-For-Tots* (cotton tipped applicators) and *Baby Cream;* also fungicidal foot powder—*Quinsana,* and *Quicool* (prickly heat powder).

Booth 13—Nestlé Milk Products, Inc., New York, N. Y.—You are cordially invited to enjoy a delicious cup of *Nescafe.* Special representatives will welcome an opportunity to answer any of your questions on Nestlé's milk products—for 80 years best known and most used for babies 'round the world.

Booth 14—Ciba Pharmaceutical Products, Inc., Summit, N. J.—An exhibit of "Economical Hormone Therapy", which features *Metandren* Linguets, the most potent oral androgen mucosa; *Lutocylol* Linguets, orally effective progestogen especially designed for sub-lingual absorption; and *Ethinyl Estradiol,* the most potent oral estrogen.

Representatives in attendance will gladly furnish literature and answer questions about these and other Ciba products.

Booth 15—Mead Johnson & Company, Evansville, Ind.—*Amigen* and *Protolysate* will be on display at your meeting. Mead Johnson has pioneered the amino acid field commercially; the products have been described in more than one hundred and forty articles in the medical literature; this year they are available. Trained representatives will be at the Mead Exhibit to discuss details of the new amino acid products. Shown also will be *Dextri-Maltose, Pablum, Pabena, Oleum Percomorphum* and the other Mead products used in infant nutrition. *Protenum,* a new high-protein product will be displayed. Also *Lonalac* for low-sodium diets.

Booth 16—Cameron Surgical Specialty Company, Chicago, Ill.—This booth is featuring the world's most brilliant headlite and the new *Omni-angle Flexible* **Gastroscope** with coated lenses. The completely boilable *Bronchoscopic* set in stainless steel, electro-surgical units in all sizes, the magnifying loupe with 10 inch focus and a complete line of Cameron Diagnostic instruments will be on display. A visit to this booth is always worth while.

Booth 17—Spencer, Incorporated, New Haven, Conn.—You are cordially invited to visit our exhibit of *Spencer Individually Designed Supports* for abdomen, back and breasts. The *Spencerflex,* a light, comfortable, masculine-appearing support for men, will be featured. This support improves posture, increases efficiency and helps prevent hernia. It is especially suitable for post-operative wear. Another support displayed will be the *Spencer Sacroiliac Corset,* designed to limit movement of the sacroiliac joints to relieve pain caused by sacroiliac sprain. The *Spencer Breast Form,* which conceals disfigurement and restores normal figure lines for the mastectomy patient, will also be shown.

Booth 18 — Pitman-Moore Company, Indianapolis, Ind.—This display will feature some new advances in sulfonamide medication designed still further to reduce the danger of crystaluria; also a recent improvement in the treatment of gastric hyperacidity and other late research developments. Laboratory scientists will be on hand to assist the Company's New York representatives in answering technical questions and explaining recent medical advances.

Booth 19—The C. V. Mosby Company, St. Louis, Mo.—New and recent releases to be displayed will include Crossen *Operative Gynecology,* Ackerman-Regato *Cancer,* Watson *Hernia,* Clendening-Hashinger *Methods of Diagnosis,* Pottenger *Tuberculosis,* Johnstone *Occupational Medicine and Industrial Hygiene,* Top *Communicable Diseases,* Jeans-Marriott *Infant Nutrition,* Eve *Handbook of Fractures,* McCormick *Pathology of Labor, the Puerperium, and the Newborn,* Treiger *Atlas of Cardiovascular Diseases,* Goar *Synopsis of Ophthalmology,* Shands *Handbook of Orthopedic Surgery,* Dunbar *Synopsis of Psychosomatic Diagnosis and Treatment* and Wiener *Skin Manifestations of Internal Disorders.* Your examination of any of these as well as the many other titles to be shown, is cordially invited.

Booth 20 — Pet Milk Sales Corporation, St. Louis, Mo.—A complete display of material illustrating the time-saving Pet Milk services available to physicians. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

Booth 21 — Picker X-ray Corporation, New York, N. Y.—The 60 milliampere *Comet* unit for fluoroscopy and radiography will be exhibited. This unit is furnished with or without a Bucky Table. There will also be on display a new 15 milliampere mobile unit especially designed for bedside work as well as numerous accessories designed for use in the X-ray department.

Booth 22—Reed & Carnrick, Jersey City, N. J.—Physicians are cordially invited to visit our booth which will feature advances in menopausal therapeusis. Deeply conscious of the far reaching obligations imposed on the medical profession in the treatment of the clinical manifestations of hypoestrinism, our laboratories have produced an estrogenic substance that conforms to the highest standards of purity and clinical efficacy. *Estrogenic Substances, R & C* (formerly Estrogenic Hormones, R & C), a highly potent, clinically dependable mixture of natural estrogens, is one of the most widely used preparations of its kind. It is available for both parenteral and oral administration. *Meprane,* a synthetic estrogen for oral administration, will also be presented. The brilliant synthesis of *Meprane* culminates eight years' intensive research for an orally potent synthetic estrogen with minimal toxicity.

Booths 23-24—Eaton Laboratories, Inc., Norwich, N. Y.—Several pharmaceutical preparations of interest to the medical profession will be exhibited.

Furacin Soluble Dressing containing a new chemotherapeutic agent Furacin (brand of nitrofurazone) will be exhibited. This compound is a new antibacterial agent recently accepted in New and Nonofficial Remedies.

Furacin Solution, a new vehicle for Furacin, will also be exhibited. This new liquid vehicle for Furacin has been compounded at the request of many clinicians for use in conditions where the soluble dressing is inconvenient or contraindicated.

Our representatives will be very pleased to discuss these products with all who register at the Eaton booth. The latest professional literature and samples will be available.

Booth 25—Sharp & Dohme, Inc., Philadelphia, Penna.—A cordial welcome is extended to all visitors. Items on exhibit include a new dosage form of *Delvinal Sodium Vinbarbital* for the production of obstetric amnesia and analgesia. New antibiotic preparations including *Tyrothricin* along with *Sulfathalidine* and *Sulfasuxidine,* intestinal bacteriostatic agents.

Booth 26—Saratoga Springs Authority, Saratoga Springs, N. Y.—This exhibit consists of a photographic montage designed to show facilities available to the public at The Saratoga Spa as part of the health service of New York State. The photographs were taken in and about the various buildings on the State's 1200 acre reservation. They display the bottling and distribution of the natural mineral waters, scenic views, recreation facilities, and various treatments using natural mineral waters as given at the bath houses. These include mineral baths and packs, as well as heat cabinet, light ray, and other treatments. State-bottled geyser water will be served by an attendant throughout the meeting.

Booth 27—C. R. Sturm, Cliffside Park, N. J.—C. R. Sturm will personally attend the meeting showing his old and reliable line of high class physio-therapy equipment, Terma built. On display will be the latest type *Commander* shortwave machine, F.C.C. approved, incorporating the most advanced structural technic; the new *Multosine* Low Voltage Generator with the built-in oscilloscope, visualizing the different pattern and waves of currents as applied to the patient. As special feature the new *Shortwave Epilator* for hair removal and minor surgery will be demonstrated. A full line of surgical instruments will be shown, also diagnostic and operating sets, and lamps.

Booth 28 — Schering Corporation, Bloomfic'd, N. J.—Important new hormone and pharmaceutical preparations will be featured. *Micropellets Progynon* is a new potent form of the female sex hormone. *Combisul* and *Combisul Liquid* are the triple sulfonamide combinations which eliminate the dangers of sulfonamide renal damage. New high potencies of *Orcton-M, Pranone* and *Progynon-B* are presented. Schering Professional Service Representatives will welcome you and will be happy to answer your inquiries concerning Schering's new products as well as the older and time-tested hormones, x-ray diagnostic, chemotherapeutic and pharmaceutical preparations.

Booth 29—C. B. Fleet Co., Lynchburg, Va.—You are cordially invited to visit this booth. Increasingly, during the past fifty years, to the medical profession, sodium phosphate has come to mean *Phospho-Soda (Fleet),* the pure, stable, aqueous concentrate of the two U.S.P. sodium phosphates.

Booth 30 — The Alkalol Company, Taunton, Mass.—This exhibit features *Alkalol,* the balanced, alkaline, saline solution for the treatment of mucous membranes and irritated tissues. It is bland, nontoxic and effective and has been a favorite since 1896. We are also showing *Irrigol,* a powder which in solution makes an aseptic, slightly astringent vaginal douche. It is widely used also for colonic irrigations and as an effective rectal enema.

Booth 31—Gerber Products Company, Fremont, Mich.—

Booth 32—Bilhuber-Knoll Corp., Orange, N. J.—This display will carry such fine medicinal chemicals as *Metrazol,* analeptic and antianoxiant; *Theocalcin,* diuretic and myocardial stimulant; *Dilaudid,* analgesic and cough sedative; *Bromural,* sedative and mild hypnotic, and their other "Council Accepted" products. The antispasmodic, *Octin,* will also be shown. Visit this display for the latest developments on these and other prescription chemicals of their manufacture. Your visits and discussions will be welcomed.

Booth 33—Philip Morris & Co., Ltd., Inc., New York, N. Y.—Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Booth 34—Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N. Y.—Among significant products featured will be *Wellcome Globin Insulin,* which provides an action which is timed to be more suitable for the average diabetic; *Tabloid Empirin Compound* with *Codeine Phosphate* gr. 1, No. 4, for relief of severe pain; Nutragest, the palatable dietary compound containing pre-digested proteins (amino acids and polypeptides), carbohydrates; and *Methedrine,* a recent sympathomimetic drug of wide therapeutic application.

Booth 35—The Liebel-Flarsheim Company, Cincinnati, Ohio.—You are cordially invited to stop for examination and demonstration of our *SW-227 FCC-Approved Diathermy Unit and Bovie* electrosurgical apparatus. Capable representatives will be on hand at all times to answer your questions about physical therapy and electrosurgical apparatus. We hope you will stop by so that we may become acquainted.

Booth 36 — U. S. Vitamin Corporation, New York, N. Y.—Enlarged color photographs of common signs of nutritional deficiency including Bitot's spots, follicular hyperkeratosis, beriberi heart, nutted edema, glossitis, cheilosis, **pellagrous dermatitis,** gingivitis, rickets, pyridoxine anemia and others. Also complimentary copies of illustrated brochure "Diagnosing Vitamin Deficiencies", "Vitamin Manual for Physicians" and other educational material.

Booth 37—Holland-Rantos Company, Inc., New York, N. Y.—*Koromex Jelly and Koromex Cream* will be featured. You may recall it was the Holland-Rantos Company, Inc., that pioneered the introduction of modern contraceptive technic—so frequently referred to as *the Koromex Method.* The medical background and clinical use of *Koromex Jelly* dates back to 1925. Medical service representatives will be on hand to discuss with interested physicians the latest data on *Koromex Jelly* and *Cream.*

Booth 38—Smith, Kline & French Laboratories, Philadelphia, Penna. — Professional Representatives will be glad to answer questions and to discuss uses in your own practice of several interesting products among which are:

Dexedrine Sulfate Tablets: Few therapeutic agents have risen so dramatically and rapidly to pre-eminence as *Dexedrine Sulfate.*

Today, its widespread clinical usefulness in depressive states and weight reduction makes this drug undeniably the central nervous stimulant of choice. *Dexedrine* is remarkable in that it spares the patient the disturbing consciousness of "drug stimulation," is virtually a "single action" drug, and has an extremely wide margin of safety.

Edrisal: Edrisal not only affords unusually effective relief from pain, but also—because it contains benzedrine sulfate in addition to acetylsalicylic acid and phenacetin—markedly improves the patient's mental outlook: a prime objective in the symptomatic treatment of painful conditions.

Booth 39—The Borden Company, New York, N. Y.—Spend a few pleasant minutes at this exhibit and refresh your memory on our Prescription Products. Meet *Biolac,* a liquid modified milk for infant feeding; *Dryco* with its high-protein, low-fat content for formula flexibility; *Mull-soy,* a liquid hypoallergenic soy food for your milk allergic patients; powdered whole milk *Klim,* a dependable source of whole milk; the improved milk sugar, *Beta Lactose,* for carbohydrate supplementation; and the powdered *Merrell Soule Protein* and *Lactic Acid Milks* for special infant feeding cases.

We also invite your attention to *Gerilac,* a vitamin-fortified powdered milk for well-rounded nutrition in convalescence, pre- and post-operative diets, geriatrics, pregnancy and lactation, and soft and liquid diets. *Gerilac* has a pleasing blank taste and variety may be enjoyed by the addition of flavors, such as vanilla, chocolate, etc. It may be served either as a beverage or used in cooking and baking.

Booth 40—Lederle Laboratories Div., American Cyanamid Co., New York, N. Y.—An up-to-date display covering several of the recent advances in medicine contributed by this company will be provided.

Folvite folic acid will be shown in its original tablet form as well as in an elixir suitable for dosage in children. *Folvron,* containing both folic acid and ferrous sulfate will likewise be shown.

Alcohol refinement will be shown in its application to the preparation of diphtheria and tetanus toxoids. The highly accurate new syphilis diagnostic involving the *Cardiolipin Lecithin Cholesterol* mechanism will be displayed. In addition, protein nutrition and its relation to *Ledinac,* a protein hydrolysate, will be discussed.

Booth 41—The Denver Chemical Manufacturing Co., Inc., New York, N. Y.—*Galatest* for the instantaneous determination of urine sugar, and *Acetone Test (Denco)* for the detection of acetone in urine will be exhibited. You are cordially invited to visit our booth for demonstration of these "spot tests" for sugar and acetone. *Galatest and Acetone Test (Denco)* offer advantages of accuracy, simplicity and economy in routine urinalysis.

Booth 42—White Laboratories, Inc., Newark, N. J.—*White's Dienestrol Tablets* (Council Accepted)—a new orally effective synthetic estrogen—are featured. Complete information and literature are available regarding the advantages of *Dienestrol's* high biologic activity, excellent patient-tolerance and economy.

Other products of White Laboratories are on display and White's Medical Service Representatives in attendance will be pleased to supply any further information requested.

Booth 43—Parke, Davis & Company, Detroit, Mich.—Members of the company's Medical Service Staff, fully informed regarding the progress in pharmaceutical and biological research, and desirous of presenting various new advancements to you, will be on hand at our Technical Exhibit to discuss new and old products. Featured, will be such outstanding Specialties as—*Benadryl, Vitamins, Adrenalin, Oxycel and Thrombin, Topical.* Also, the most recent types of *Biologicals,* including other therapeutic agents of chemotherapeutic interest, will be displayed. We invite you to visit our Exhibit while attending this Meeting.

Booth 44—M & R Dietetic Laboratories, Inc., Columbus, Ohio.—*Similac,* a food for infants deprived either partially or entirely of breast milk, will be displayed. Messrs. D. F. Schlosser and M. Goldwater will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

Booth 45 — Endocrine Company, Union City, N. J.—Displaying endocrine and vitamin products.

Booth 46—Camel Cigarettes, New York, N. Y.—*Camel Cigarettes* will present a dramatic full color review of their recent medical research on smoking, as well as the details of the nationwide survey showing that "More Doctors Smoke *Camels* Than Any Other Cigarette." Another panel will illustrate the absorption of nicotine in the respiratory tract.

Booth 47—Lanteen Medical Laboratories, Inc., Chicago, Ill.—You are cordially invited to visit this exhibit. Featured will be *Procarmin,* a protein autolysate with high amino acid and vitamin content.

Natural and synthetic estrogen will also be available, including *Estrogel,* a highly purified preparation of estrone and other natural estrogenic steroids for percutaneous administration.

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THE MEDICAL SOCIETY OF NEW JERSEY
ANNUAL REPORTS TO THE HOUSE OF DELEGATES

APRIL 26-29, 1948

PRESIDENT

Royal A. Schaaf, M.D., Newark

During the war years the activities of our Society were greatly curtailed because of the absence of so many of our members in the medical corps of the Armed Services and the preoccupation of the remainder with the demands of civilian practice and the many projects connected with the war effort. Immediately following VJ Day, however, our members were rapidly discharged from active duty and returned to their homes to pick up the threads of their interrupted professional careers. By the beginning of the present administrative year demobilization had been almost completed and our Society was able to resume full scale activity.

The year has been a very active one with many important projects being carried out concurrently, all of which are adequately presented in the reports of the respective committees published in the following pages. Each committee has exhibited commendable industry and enthusiasm and much constructive work has been done. Many individuals have contributed unstintingly of their time and energy in their effort to carry out the various programs. To the committees generally and to each individual member personally, the Society owes a debt of gratitude for their contributions to our collective welfare.

Although it would be unfair to single out the labors of any one committee for particular mention, it would be ungrateful to make no reference to the magnificent work of the Woman's Auxiliary under the presidency of Mrs. Mancusi-Ungaro and the public relations chairmanship of Mrs. Yaguda. The Auxiliary planned and undertook a most ambitious program, all items of which have been carried out successfully, most notably, the Round Table Conference on June 16, and the development of the County Councils on School Health. On behalf of the Society, I extend to the officers and members of the Woman's Auxiliary our most sincere thanks.

With the advent of Mr. James E. Bryan as our Executive Officer on September 1, 1947, our public relations program was resumed, a large part of it having necessarily been abandoned upon the death of Dr. Wilkes in 1942. Our progress in effecting a cordial relationship with governmental and lay groups interested in health and welfare has been most gratifying.

Special attention has been given to effecting a better liaison between the State Society and its component county units. By the end of this administrative year every component society will have been visited by a member of the official family and by our Executive Officer.

Our Annual Meeting has been lengthened to four instead of three days in order to give each of the fourteen sections time for a program of its own.

Special mention should be made of the excellent work of Mr. Bryan and Mrs. Madden. Mr. Bryan has demonstrated his administrative ability and his clear conception of the requirements of a Public Relations Officer. He has been indefatigable in the execution of all duties assigned to him and in his contacts with the public he has reflected great credit upon The Medical Society of New Jersey. Words would be inadequate to express my personal appreciation of the loyal cooperation of Mrs. Madden and her competent staff. She has conducted the internal affairs of the Society most capably, never slighting or overlooking the minutest detail. Her planning of the forthcoming Annual Meeting has been superb in every respect and we may confidently anticipate an unusually successful meeting.

The death of our immediate Past-President, beloved Frank G. Scammell, in December 1947, is noted with sorrow. We shall miss the presence of a genial, friendly, kindly and courageous man.

In conclusion I wish to express my sincere thanks to the officers and trustees and to many of our elder statesmen for the unfailing and sympathetic support which they have given me during the past year.

SECRETARY

EARL LEROY WOOD, M.D., Newark

The Secretary performed the duties of the office as prescribed and attended the Conference of State Medical Association Secretaries and Editors, November 7 and 8, 1947, in Chicago.

The following is the statistical report on the Official List of Members of The Medical Society of New Jersey, as of March 1, 1948:

Active Members, 1948:		
Paid-up	4,559	
Discharge Credits	11	
Service Credits	17	
		4,587
Associate Members, 1948:		
Paid-up	238	
Service Credits	7	
		245
Members Deceased, March, 1947-March, 1948		52
Transfers, March, 1947-March, 1948:		
In from Other States	52	
Out to Other States	35	
Within State	27	
		114
Resignations, March, 1947-March, 1948		12
New Members		199
Reinstated Members		28
Delinquent Members (members in 1947, not paid at time of Official List closing)		283

TREASURER

GEORGE J. YOUNG, M.D., Morristown

As the fiscal year does not close until May 31, 1948, the annual report cannot be submitted at this time. An interim report covering the accounts up to that time will be presented to the House of Delegates at its Annual Meeting this April.

BOARD OF TRUSTEES

ALDRICH C. CROWE, M.D., Chairman, Ocean City

The reorganization meeting of the Board of Trustees was held on April 24, 1947, during the Annual Meeting in Atlantic City. At this time officers were elected and committee members were named. The Trustees reaffirmed their approval of the activities of the National Physicians Committee. The full report of this meeting will be found on page 281 of the July 1947 JOURNAL.

A second meeting of the Board was held in Atlantic City on June 8. Approval was given Dr. Scott's pamphlet *Implementing the National Health Program;* such approval also included the *Principles of Cooperation of The Medical Society of New Jersey with Health and Welfare Agencies* as listed in the pamphlet. This pamphlet was printed and forwarded to the A.M.A. Council on Medical Service for distribution. A report on the new contract submitted by the Veterans Administration, abandoning the liaison officer arrangement, was presented. It was decided that all negotiations regarding this contract would be left to Medical Service Administration. A review of the hearing on S. 545 (held in Washington on June 5) was given by President Schaaf and Dr. Quigley. Action was taken on recommendations of the Welfare Committee which were presented for consideration. The full report appears in the August 1947 JOURNAL on page 327.

At the September 28 meeting, Mr. Bryan, newly appointed Executive Officer, was introduced. Recommendations submitted by the Cancer Control Committee, with particular reference to the Mountainside Plan, were approved. The program of the 1948 Annual Meeting, including the extension of the convention to a four day program was ratified. In conformity with the A.M.A.'s request, members were named to a Joint Committee of Physicians and Dentists. A few changes in

title and the reappointment of salaried personnel were ratified.

Among other matters given favorable consideration were (1) Endorsement of a New Jersey Chapter of the American Diabetes Association; (2) Receipt of the nomination of New Jersey candidates for the A.M.A. award to the most distinguished general practitioner; (3) Establishment of a similar New Jersey award; (4) Sanction of recommendations forwarded to Governor Driscoll for appointments to the Advisory Health Council.

At the request of Mr. Hendricks, Secretary of the Council on Medical Service of the A. M.A., approval was given the suggestion that The Medical Society cooperate with the A.M. A. in the evolution of principles of a national health program. Special committees were appointed and various recommendations of the Welfare Committee were acted upon. See the full report on page 461 of the November 1947 Journal.

A special meeting of the Board was held in Trenton on November 16, 1947. Considered at this session were resolutions on the establishment and conduct of clinics, and on the subsidization of nurses training schools and state payment for hospital care of the indigent. Both were approved. Endorsement was granted to the New Jersey Chapter of the American Heart Association. President Schaaf was authorized to sign Contract No. 2 with Veterans Administration; authorization was also given the President to transmit the approval of The Medical Society of New Jersey of the *Revised Manual of Standards for Private Hospitals in New Jersey.* Two requests to name advisory committees were filled; one from the National Foundation for Infantile Paralysis and the other from the Commissioner of the State Department of Labor. A full report of this session will be found on page 507 of the December Journal.

At a meeting in Trenton on January 11, 1948, the Board selected the membership of the Advisory Committee to the Hospital Licensing Board. The Trustees were informed that, with the signing of Contract No. 2, Medical Service Administration was no longer concerned with Veterans Administration. President Schaaf was empowered to approve the *Manual of Standards for Practical Nurses,* after reconciliation of differences. Approval of membership in the New Jersey State Chamber of Commerce was expressed, and the Board went on record as favoring the Executive Officer's affiliation with organizations engaged in the promotion of public health and welfare. The Trustees authorized the Committee on Post-Graduate Education to accept designation as the medical advisory committee to Rutgers University. A report of the Delegates to the A.M.A. was received, including an account of the New Jersey resolutions introduced at the January session. No action was taken on the resolution relative to S. 545, and a second resolution calling attention to the unsatisfactory distribution of interns and advocating a year's general rotating internship, passed the House and was referred to a special committee for study. A comprehensive report of Medical Service Administration was received. This was printed in full in the March 1948 Journal. Action was also taken on many Welfare Committee recommendations.

At the regular meeting of the Board on March 14, 1948, the resolution previously approved on ambulatory private patients was amended with the insertion of the word "where *adequate* facilities are available in private physicians' offices". The Executive Officer was designated as the Society's representative to attend the National Health Assembly in May in Washington, D. C. The Advisory Committee on Cancer Control was named as the official Medical Advisory Committee of the State Society to the New Jersey Division of the American Cancer Society; the Advisory Committee on Crippled Children as the official Medical Advisory Committee to the New Jersey Chapter of the National Foundation for Crippled Children and Adults, Inc., and the Advisory Committee on Cardio-Vascular Diseases as the official Medical Advisory Committee to the New Jersey Health Association.

Two recommendations for amendment to the Constitution and By-Laws, one on the duties of the Judicial Council, the other on the composition of the Board of Trustees, were referred to the Reference Committee on Constitution and By-Laws. Nomination of Mr. William H. MacDonald to Honorary Membership in the State Society was endorsed. The Board recommended three nominees to Governor Driscoll for consideration in the appointment of a member of the State Board of Medical Examiners.

Upon invitation, the Board accepted cosponsorship with the State Department of Health for two sectional meetings in June under the auspices of the National Foundation for Infantile Paralysis, Inc. Mr. Gerald F. O'Mara, (associated with Mr. Albert C. Wall prior to his death) was designated as counsel to The Medical Society.

The ten-point program of the Auxiliary for 1948-49 was approved and the Auxiliary au-

thorized to give a cash prize to the County Auxiliary having the largest ratio of members in lay organizations concerned with public health.

Many recommendations of the Welfare Committee were considered and necessary action taken. With one deletion and a few minor changes the report of the Special Committee on Study of Medical Care, (to be presented to the House of Delegates) was approved. Reports of Medical Service Administration on medical care of old age assistance clients with principles of a proposed medical program, and principles of medical care of wards of the state board of child welfare, were approved.

Communications received since the last meeting were considered and necessary action taken including the appointment of two representatives to a State Advisory Committee to the State Board of Education to consider plans for the expansion of the program for the training of practical nurses in vocational schools of the state, and nomination of a member to the Board of Trustees of the Hospital Service Plan of New Jersey. A full report of the minutes of this meeting will appear in the May 1948 Journal.

SPECIAL COMMITTEES

STUDY OF MEDICAL CARE

Norman M. Scott, M.D., Chairman, Newark

Report of committee appointed by action of the 1947 House of Delegates to "crystallize the mechanism of approach to the problem of providing good medical care to every citizen of New Jersey". The committee appreciates that such an assignment involves problems for many of which there is no specific answer today.

Good medical care is dependent upon many factors, such as proper food, proper clothing, adequate medical facilities and personnel, education and training of physicians, environmental surroundings of the patient and even the personalities of the physician and patient. The solution of the problem by sound, practical methods, must be evolutionary in character over a period of years, will require the cooperative action of voluntary groups, our communities, government and the medical profession. Its evolution must parallel the advancements in medicine and the socio-economic philosophy of the people.

Advances in providing good medical care to the people of New Jersey in the past have, for the most part, been led by the medical profession since before the days of the Revolution and are reflected in the history of The Medical Society of New Jersey.

THE BIRTH OF MEDICINE IN NEW JERSEY

In the early days of medicine in New Jersey there were no medical schools, no hospitals, no formally educated physicians and no laws governing the practice of medicine. Many practitioners were self educated, through reading of the scant medical literature available to them, following which they set themselves up as doctors. barber-surgeons, or male-midwives. The state was rife with charlatans and quacks. A more formal type of education was available through the preceptor method, under which a young man placed himself under the preceptorship of an accomplished physician for a period of training.

The Medical Society of New Jersey was organized in 1766 by some of the more accomplished physicians of the State. They were cognizant of the lack of proper medical education of many practicing physicians. One of the first actions of the Society (1767) was to improve the standards of education through preceptorships by enunciating that "no member shall take an apprentice unless he has competent knowledge of Latin and some initiation of Greek. No member shall take an apprentice for less than four years, the fee to be 100 pounds a year". This form of education was prevalent until the medical schools of Pennsylvania and New York developed educational standards which were an improvement over the preceptor method. Medical school education was developed on an evolutionary basis following the establishment of University of Pennsylvania School of Medicine in 1765 and Columbia University College of Physicians and Surgeons in 1767. Formal medical school education gradually supplanted the preceptor system but the latter was still in vogue during the first half of the nineteenth century.

In the following year (1768) the Society petitioned the Legislature, which passed the first law regulating the practice of medicine.

Under this statute, an applicant was examined by a Justice of the Supreme Court to determine his suitability for a license to practice medicine. After the Revolution, the Supreme Court turned over to our Society the authority to examine and license physicians. And so, medicine, as we recognize it in New Jersey, was born. This method of licensing physicians continued until 1890 when the Society, convinced that the adequacy of medical education and the licensing of physicians should be under state control, petitioned the Legislature for enactment of the first Medical Practice Act.

Education of the physician, development of the highest standards of medical care and the advancement of all means for promotion and guarding the health of the people of New Jersey have been the prime objectives of the Society through the years. And in 1847, the newly organized American Medical Association began its effective work of advancing the standards of medical schools on a national basis. The program of the Society in recent years to promote medical education has consisted of advising upon legislation to maintain and raise the educational standards required for a license to practice medicine in New Jersey and promoting graduate courses for members through its county societies and with the cooperation of Rutgers University and Seton Hall College.

THE HOSPITALS OF NEW JERSEY

No hospital facilities were available in New Jersey until 1848 when the Trenton State Hospital for Mental Diseases was established. This was followed in 1863 by the construction of St. Mary's Hospital in Hoboken. From then on, hospitals were established by various religious organizations, the citizens of our municipalities, by counties and by the state until by 1900 the capacity of our hospitals totalled 5000 beds. Since 1900, largely through the expansion of our voluntary hospital system, the capacity of the hospitals of New Jersey has increased to 42,600 beds in 1946 of which 16,500 were general hospital beds, 3600 for the care of the tuberculous and 4500 for the care of chronic and convalescent patients.

An important factor in the support of our voluntary hospitals and in making hospital facilities available to our people is The Hospital Service Plan of New Jersey which has a current enrollment of over one million persons entitled to benefits toward defraying the cost of hospitalization.

THE NEW JERSEY DEPARTMENT OF HEALTH

During the last half of the nineteenth century, as New Jersey developed more and more rapidly into an industrial state, and as the road system and transportation facilities improved, the population became progressively more urban than rural. This resulted in the ever present danger of rapid spread of contagious diseases, typhoid fever, cholera and other infectious diseases prevalent during that time. While some of the larger municipalities had organized health departments or boards there was no means of controlling the spread of disease on a state wide basis. The first legislative recognition of this problem was in 1865 when through action of the Legislature a State Sanitary Commission was formed to report upon the general sanitary condition of the state, prevention of epidemic and contagious diseases and such other facts and advice as would conduce action for the promotion of public health. In 1873 the Legislature created the State Health Commission, the reports of which led to the law of 1877 creating the State Board of Health. This Act, among other provisions, required the establishment of a Board of Health in each municipality, coordinated through the State Board of Health. By subsequent legislative acts, the functions of the Board were broadened. In 1915 the Board was abolished and a Department of Health was created. The latest reorganization of the Department became effective in July 1947.

By this evolutionary process has been developed our modern Department of Health, the functions of which have been progressively expanded to parallel the ever advancing front of scientific knowledge in the public health field. During the years its work has had a tremendously beneficial effect in improving the health of the people of this State.

THE DAWN OF SCIENTIFIC MEDICINE

Medicine in New Jersey, as elsewhere, in the old days was almost exclusively an art. The physician learned, if he did not close his eyes, by his observations at the bedside, and if he was more fortunate and ambitious by his observations of gross pathology at the autopsy table. If he was successful he knew the background of his patient and of his patient's family, his personality, his "constitution", his weaknesses and his strengths. With this background and by applying a process of deduction he determined the diagnosis and applied the limited, traditional treatment which was indicated. Medicine as a science was unknown to him, and he thought, conscientiously, that he knew all that was to be known in his field. As scientific medicine awakened, its spread was slow, due to conservatism on the part of physicians, the lack of current literature, poor

transportation and lack of close association of the individual physician with other physicians.

In the latter half of the nineteenth century, centering around the medical schools and hospitals, the advance of scientific medicine, as we know it today, began. The discovery of anesthesia, making painless surgery possible, was probably the most dramatic development; the discovery of the cause of puerperal fever, the development of antiseptic and aseptic surgery, the recognition of bacteria as a cause of disease, the development of the stethoscope and clinical thermometer, advances in knowledge of bacteriology and pathology, recognition of means for controlling contagious diseases, particularly the discovery of diphtheria antitoxin; and the beginning of differential diagnosis of disease through laboratory procedures, were the basis for the more rapid advance in scientific medicine which took place after 1900. Again, of course, there were delays in applying these advances to the welfare of the people, due as always, to time necessary for the education of physicians, time necessary for the appreciation of their value by the people, and the development of the necessary facilities with which to apply them.

THE HEALTH OF THE PEOPLE SINCE 1900

Since 1900 there has been a phenomenal advance in the science of medicine. There has also been a great improvement in the economic condition of our people, resulting in better housing, better food and better sanitary surroundings.

These advances in medical science and improvements in the standards of living have produced remarkable improvement in the health of the state and its individual citizens. For example, in New Jersey between 1900 and 1946, the mortality rate of typhoid fever fell from a rate (per 100,000) of 18.7 to .07, diphtheria from 43.3 to 0.3, tuberculosis from 186.4 to 38.7, and the general death rate from 16.6 to 10.7 per thousand. Life expectancy increased from 49 years to 64 years;—a gain of 15 years in the life of the average individual since 1900.

CHANGES IN MEDICAL PRACTICE

Medical practice has changed, from the day when the general practitioner with his bag, his stethoscope and prescription pad, could apply all that was known about medicine. As modern medicine developed it required elaborate and expensive equipment such as x-ray and clinical laboratory facilities to provide the technics for modern diagnosis and therapy. This need was largely supplied through expansion of our voluntary hospital systems, contributed by the people of our communities. Modern medical care frequently requires the facilities found only in modern hospitals and the services of several physicians in addition to nurses, interns and technicians. This makes modern medical care expensive;—too expensive for many people except on a prepayment budget arrangement.

Many, everyday examples, of the advantages and expenses of modern medical care might be mentioned. For instance, appendicitis in the old days was treated by hot poultices, perhaps an enema and opium derivatives to control pain. The cost was low, the mortality high. Today it involves modern hospital facilities, diagnostic laboratory procedures, elaborate operating room equipment, the services of one or more surgeons and nurses; the cost is high, the mortality low. Diabetes, in the old days, was treated by low sugar diet. The cost was low, the mortality high. The modern treatment of diabetes requires close laboratory supervision and the use of insulin; the cost is high but the patient leads a normal life of almost normal life expectancy.

THE PRESENT PROBLEM

There is an ever increasing demand by the people that the advantages of modern scientific medicine be made more easily available to all people regardless of economic status. The demand has created a real challenge to the medical profession.

It is argued that there are not enough physicians and nurses to meet the need, that there is a lack of hospital facilities, that persons of low income cannot obtain adequate medical care and that persons of modest income cannot afford to pay for adequate medical care; but there is no common opinion as to the actual needs, or the means by which these needs may best be met.

No question has been raised as to the standards and adequacy of medical care available in New Jersey. The question is how this high standard care can be made attainable by *all* people. Some argue for voluntary insurance, others for a compulsory system operated by the government, and still others for a combination of both.

THE NEW PHILOSOPHY

In recent years there has occurred in this country, a gradual change in the social and political philosophy of many of our people, and, the evolution of new social concepts and political theories. These new concepts and theories would shift the responsibility for personal welfare from a basis upon which the individual is responsible for his own welfare,

more and more to a basis upon which government assumes responsibility for the welfare of the individual. This is primarily an economic and political problem. It is a problem for the people as a whole to determine how far this socio-political trend is necessary, or should be allowed to extend for the best interest of the people.

This new philosophy is reflected in legislation proposed as a solution for the medical care problem now before the Congress.

The medical profession wants this problem solved in accordance with our traditional democratic form of government, acknowledging the autonomy of our states and the right of the individual state to solve this problem. It wants the problem solved at a local level to meet local needs, under local control, rather than on a national level with federal control. It believes the individual should, and wants to assume responsibility for his own welfare in so far as this is economically possible, supplemented in whole or in part by tax subsidy for those persons unable to provide for their own needs from their income.

ACCOMPLISHMENTS TO DATE

As an approach to the solution, the medical profession recognizes four socio-economic groups:

(1) Persons whose income is sufficient to meet the cost of adequate medical care.

(2) A large group of employed persons who need financial assistance to meet the expense occasioned by serious illness.

(3) The "medically-indigent"; persons whose income is sufficient to meet the routine expenses of adequate food, clothing and housing, but insufficient to meet the cost of adequate medical care, occasioned by major or minor illnesses.

(4) The indigent.

In 1940, the Legislature enacted a law sponsored by The Medical Society of New Jersey providing for the organization of non-profit medical service plans. Under the provisions of this legislation the Society organized two corporations, Medical Service Administration of New Jersey and Medical-Surgical Plan of New Jersey.

To meet the assumed need and demand of employed persons the Society first sponsored a plan to provide payment for general and special professional care in the home, office or hospital, under which complete payment would be provided for services rendered families with incomes below $2400 a year (in 1940). The cost of this plan was to have been $4.50 per month per average family. It was introduced into many industrial organizations but met no demand. Employed persons expressed little interest in protection for themselves on an insurance basis against the cost of general medical care. They did express interest in protection against the cost of serious or catastrophic illnesses. This experience led to the evolution of Medical-Surgical Plan of New Jersey. In this plan, a serious illness was defined as one requiring treatment in a hospital. It is appreciated that this is not a perfect definition of a serious illness, but it does cover probably 95 per cent of the unpredictable type of serious illnesses which are a particular financial hardship to persons of modest income. This formula also provided a well defined group for study in determining costs, which was accomplished through the study of 10,000 cases admitted to hospitals for treatment. The plan provides benefits toward the cost of medical, surgical, obstetrical, consultation and anesthesia services rendered to eligible persons admitted to hospitals for treatment. The 3700 participating physicians agree to deem the benefits payable by the plan as complete payment for eligible services rendered eligible persons with below average incomes as set forth in the contract. The current enrollment (January 1948) is 155,000 persons. The subscription cost is 75 cents a month for the Single Person Contract and $2.00 per month for the Family Contract.

The only source of income for the payment of medical care rendered the indigent and medically indigent is tax money. Medical care of the indigent under state law is a responsibility of the municipalities. State money is available to all municipalities to defray part of the municipal cost of this care, averaging 40 per cent of the cost, through the Bureau of Municipal Aid of the Department of Economic Welfare. Care of the medically indigent requires a definition of the term "medical indigency" on the part of the municipality providing payment for the medical care rendered.

An example of what may be accomplished by the cooperative action of government and profession, working at a local level to meet a local need, is the City of Newark Medical Plan operated by Medical Service Administration. This is not an insurance project. It is a "reimbursement" plan under which the indigent and medically indigent of the city are allowed free choice of physician and physicians are paid on a fee-for-service basis. Medical Service Administration pays physicians for approved eligible services and is reimbursed by the city at monthly intervals, plus 10 per cent for administrative cost. Medical indigency in this instance is determined by the Social Ser-

vice Bureau of the City Board of Health. The association between Medical Service Administration and the city departments has been most pleasant. The plan meets with approval by the city, the profession and the patients. From this experience was evolved the *Principles of Cooperation Between Organized Medicine and Health and Welfare Agencies* as approved by the House of Delegates of the Society in 1947 and later, in the same year, by the House of Delegates of the American Medical Association. The principles are adaptable to a solution of the problem in any municipality in the state.

RECOMMENDATIONS

Physicians. There has been no formal demand for additional physicians in any area of the state and the committee is aware of no area in New Jersey without a physician in which the population is sufficient to support one. The committee concludes that the number of physicians practicing in the state is reasonably sufficient to meet the needs of the population.

Of the 5655 fully licensed physicians residing in New Jersey, 4981 are in private practice. This is a ratio of one private practitioner to each 835 persons. The optimum number of physicians necessary to render adequate medical care to a given number of persons is dependent upon many factors: perhaps one to 750 is the most generally accepted figure. With a large proportion of the fully licensed physicians not in private practice but actually rendering medical care (as full time employed physicians in industry, state and county hospitals) it seems fair to assume that New Jersey does enjoy the optimum of one-to-750. The distribution of physicians varies from one-to-622 in Essex County to one-to-1281 in Salem County. The ratio of physicians to population is lower in rural centers. This is understandable because many patients from rural areas are referred to physicians in urban areas for treatment and consulting services.

The committee recommends that The Medical Society of New Jersey

1. Expand, and further develop its program for graduate instruction of physicians.
2. Continue its efforts to maintain a high standard of personnel practicing in New Jersey by recommendations to the Legislature governing the requirements for a license to practice medicine.

Public Health. The committee recommends that all functions generally accepted as "public health" functions be organized on a county or other "service area" basis in all except Class I and Class II counties; each area representing not less than 25,000 population. Each such area should be provided with a qualified, full time Health Officer,Sanitary Engineer or qualified Sanitary Inspectors and Public Health Nurses and such other qualified personnel as are necessary to meet the needs of each area. Particular emphasis should be placed upon "health instruction" as a function of public health nurses.

Nursing Services. There is a serious shortage of nurses in the state. This has developed for several reasons, among which are: the increased demand for nursing services, the great increase in use of hospitalization, (estimated to have doubled since 1935), the development of specialties within the nursing profession and the new opportunities offered for nurses through federal government services, industry, public health, and specialized services such as psychiatry and surgery. There are 19,000 graduate nurses available in New Jersey of whom 12,000 are active. Of these, some 2200 are in private practice, the remainder being employed in industry, hospitals, government, public health organizations and military services.

There are 42 schools of nursing in the state to which 860 students were admitted during the year 1946-47. This is a reduction of over 50 per cent from the number entering during recent previous years and is probably due to discontinuation of the Cadet Nurse Corps established during the war. It is estimated that 1200 new graduates each year from our 42 schools of nursing are necessary to meet the needs of the state.

The committe recommends:

1. That the educational and public relations program now in effect to acquaint young women with the advantages of nursing as a career be expanded.
2. Since adequate nursing personnel is essential to the health and adequate medical care of the people of the state, state money should be made available for the support of the schools of nursing in New Jersey.
3. That the program for the training of practical nurses as provided for in legislation recently enacted, be expedited.
4. That greater utilization of home service of the Public Health or Visiting Nurse by our municipalities and individual citizens be encouraged.

Hospitals. We recognize that there is an existing and pressing need for more hospital beds. This need is urgent for the mentally ill; it is increasing rapidly for the care of the long-term and chronically ill patient; and the need for more general hospital beds is acute in some

areas. It is recommended that the work of the present Advisory Hospital Council on which the medical profession is adequately represented, under the Department of Institutions and Agencies, be supported.

The plight of the general voluntary hospitals in meeting their operating costs is urgent, and the committee believes that some form of additional muncipal or other governmental subsidy is needed.

Medical Care of the Indigent and Medically Indigent. We recommend that the medical care of the indigent, (and of those otherwise self-supporting persons whose income is insufficient to secure adequate medical care), be provided by tax subsidy from municipalities with aid from higher echelons of government. The determination of eligibility for, and care under, this tax supported program should be at a local level.

The Care of the Chronically Ill. The chronically ill patient, who is incapacitated for work, is usually happier in his home surroundings, if the home atmosphere is satisfactory and if he is provided with adequate medical care and advice, adequate food and adequate clothing. He may require periods of hospitalization for diagnostic purposes, necessary surgery or the treatment of acute exacerbations or intercurrent illness. This may be rendered in any general hospital, but this type of patient frequently does not need prolonged institutional care. That there is need for additional hospital facilities for the care of these patients is apparent; and to the extent needed, should be provided by additional units associated with, and part of general hospitals; but the committee questions the need for the extensive facilities recommended by some.

In view of the present high cost of hospital construction and per diem cost of a hospital bed, the committee recommends the evolution of a program under which the needs of such patients may be met in their homes, or foster homes, to include medical care, nursing care and housekeeping services. Such a program would be applicable to the majority of chronically ill patients, and the committee believes, at less expense than the cost of hospitalization. The care of the chronically ill would be facilitated if in each county there was established a "Register of Needy Chronically Ill Persons" and recommends that such a register be established in each county through the cooperation of a voluntary agency and the county medical society.

Medical Care of Self Supporting People. Self-supporting people do not desire a complete medical care program on a prepayment insurance basis, largely because of its cost; and because they feel that while employed they can provide for the payment of the cost occasioned by minor illnesses. Their expressed need is for protection against the cost of serious or catastrophic illnesses. The Medical Society has already taken steps to meet this by organization of the Medical-Surgical Plan of New Jersey. The committee recommends that Medical-Surgical Plan be expanded as rapidly as is possible and consistent with the actuarial and financial safety of the plan.

In closing, the Committee wishes to emphasize its belief that the medical care distribution program in New Jersey, while not entirely satisfactory, is essentially sound. Measures are now being taken to further overcome the inadequacies. The program of the future must continue along evolutionary lines and will require the intelligent and continued cooperation of the public and the medical profession.

VETERANS LIAISON

Joseph F. Londrigan, M.D., Chairman, Hoboken

On November 22, 1947, the new agreement with Veterans Administration, dispensing with the services of a liaison officer, was signed. If, at the termination of the contract (June 30, 1948) such an officer is found to be necessary, the contract may be renegotiated.

Arrangements have been made with the Manager of the VA Regional Office to retain the former liaison officer's secretary in her position to carry on the necessary detail work with relation to the physicians, and to have those of our members who are employees of VA, act as consultants in emergencies on any matter concerning the Medical Society.

Examining boards are no longer functioning. They will not be used unless there is some large project of re-examination. At present, VA does not contemplate using these boards.

The corporations created in each county and known as The (name of county) Plan for Veterans Care, are continued.

MILITARY SERVICE

R. L. SHARP, M.D., Chairman, Camden

Since the questionnaire sent out by the Military Committee of the American Medical Association, there have been no further requests for information from them, nor have there been any problems in our own state. Consequently, our Committee has not met this year.

JUDICIAL COUNCIL

FRANCIS C. WEBER, M.D., Newark, VINCENT P. BUTLER, M.D., Jersey City, BARCLAY S. FUHRMANN, M.D., Flemington, S. EMLEN STOKES, M.D., Moorestown and CHESTER I. ULMER, M.D., Gibbstown.

No problems were presented for the consideration of the Judicial Councilors, and no affirmative reports have therefore been entered.

EXECUTIVE OFFICER

JAMES E. BRYAN, Trenton

This is the first annual report the newly incumbent Executive Officer has presented to The Medical Society of New Jersey. During the seven months I have had the privilege of serving your Society, I have gained a great respect for the traditions and public policies you have developed over the years, an enthusiastic belief in the future of your Society, and a deep affection for those of its members with whom I have been working.

My ultimate responsibility to the Board of Trustees is general, involving the execution of your programs and policies, the conduct of your relations with the County Societies, with outside agencies and the public. As contemplated by the Trustees, the actual day by day management of the internal affairs of the Society is delegated to Mrs. Madden, our Executive Assistant, and the members of her competent staff. This has left me free to concentrate upon renewing and extending our contacts with cooperating agencies and building up a comprehensive program of public relations.

I should like to record my personal appreciation of the cooperation given me by all the members of our executive staff. Especially would I emphasize my gratitude to Mrs. Madden. Her great ability, her unfailing devotion to the Society and her generous aid in familiarizing me with the requirements and opportunities of my new assignment have been of immeasurable help.

Our work is developing a program of public relations is set forth in the report of the Subcommittee on Public Relations. My comments will be general:

I conceive of public relations as being primarily a matter of public service. The blood, bones and sinews of any public relations program are the progressive policies and programs of the Society, designed to provide better health protection and more and better medical care for the people. Hence the *primary* task in any public relations program is to take the purposes and programs of the Society and make them come alive in every nook and cranny of the State.

This job—of activating your wishes and policies at the local level—is all too frequently neglected. Time and again, in every medical society, a worthy plan of public service is thought out and formulated at the state level—only to be filed away in the archives, gathering dust. The average doctor going his daily round, and the "man in the street"—presumably the intended beneficiary of all this central thinking and planning—neither of them ever hears of the program. And while The Medical Society as such may derive a fleeting ephemeral credit for proposing the program, it fails to realize the more substantial public notice and prestige that would follow in the wake of a determined, continuous statewide effort to put its plan or program into effect.

This, then, it seems to me, is the number one job of any man who aspires to accomplish anything of tangible value to you in the

field of public relations. If, as and when we succeed in *realizing* our programs, in such matters as medical care for the needy, voluntary medical care insurance, local health department reorganization, improvement in school health, heart disease control, in cancer, tuberculosis, maternal welfare, etc.,—it follows, as the night the day, that the public will be appreciatively aware of our primary devotion to their health and welfare.

To illustrate this point, let me call attention to two areas in which we have made a particular effort to carry out our well-thought-out objectives and policies. There are other fields, of course. But I refer particularly to the school health program and our program for cancer control.

In both cases, our policies are clear and progressive; in both, we have had the energetic help of lay organizations; in both, we have cooperated closely with our component societies; in both, we have received an immense amount of favorable public notice. And, lest we forget, in both cases we have started something that will require of us not less, but more and more, effort as time goes on. I cannot leave this subject without taking special appreciatory note of the incalculable aid given us by our own Woman's Auxiliary in the school health program.

I come now to the main point of this report. The Medical Society of New Jersey, it seems to me, is well equipped with policies and objectives. You have well defined attitudes and plans with respect to nearly every issue or problem confronting you. The job, now, is execution. The need is to make your proposals come true.

To accomplish this, the basic groundwork has been done. We have developed mechanisms to reach the individual doctor and the component medical societies, through whom your plans and purposes must eventually be brought to life in every community. I refer to our Membership *News Letters,* our program of county society visitation by the presidential officers and the Executive Officer, and our many other special contacts with members in every part of the state.

In furtherance of a closer, more effective working relationship with the County Societies during the coming year, special all-day conferences are planned, late in the spring and early next fall, with certain officers and committee chairmen of the county societies on public relations, "Public Health Week" and other individual projects.

When one works day by day on the endless task of executing the programs of an active alert state medical society, he cannot help thinking sometimes that it would be a grand thing if we might declare a moratorium, for a few months, on new policy making, or the putting forward of new plans and projects. Time might be gained in which we could digest some of the many dishes we have ordered to be eaten.

I do not go so far as to offer such an impossible proposition as that. Time marches on, new problems arise, and we must all struggle to keep abreast of them.

But I do most respectfully suggest that we transfer our emphasis, so far as we can, in the months ahead, to the task of *accomplishing* our primary plans and programs.

One of the most urgent recommendations of the American Medical Association is that state and county societies take the initiative in forming local health councils, in which medicine may work with other interested groups in each community to implement sound, progressive health programs.

We have made a beginning in forming our School Health Councils. Perhaps these councils should be expanded to interest themselves in other health problems. We have many important suggestions to offer such community health councils.

There are four major programs that immediately offer themselves for consideration:

(1) To popularize and extend the use of the Medical-Surgical Plan for voluntary prepayment insurance.

(2) To organize local programs for the care of the indigent and medically indigent, according to the proved principles developed by Medical Service Administration. (In event of a deflation producing unemployment, these local plans should be immediately ready to go into effect.)

(3) To complete our school health improvement program—("The Four Point Plan")—by organizing school health councils in every school district within each county.

(4) To begin the long task of local education necessary to take advantage of legislation permitting establishment of county or part-county health departments. (If this bill fails to pass, our educational effort should be geared to creating a demand for its passage next year.)

Other equally desirable major objectives will occur to some of you, but these will illustrate the chief burden of this report.

I conclude by thanking the officers and many members of the Society for the friendly, helpful way in which they have received me into their ranks. I am proud indeed to be working in the service of The Medical Society of New Jersey and I hope I may be increasingly useful to you for a long time to come.

STANDING COMMITTEES

FINANCE AND BUDGET

David B. Allman, M.D., Chairman, Atlantic City

The Committee on Finance and Budget has reviewed the expenditures of the current year as well as the budget requests for 1948-49. We find reflected there, the trend of the times. It is definitely costing more to operate The Medical Society of New Jersey than ever before. This of course is true of all business. A continued increase is to be expected if the activities of the Society in your interest and in your behalf are not to be curtailed.

A tentative budget has been worked out, but in-as-much as our fiscal year does not end until May 31, 1948, it is necessarily incomplete at this time.

In 1946 the Medical Society of California raised its assessment from twenty dollars per member to one hundred dollars. South Dakota and Utah each recently raised theirs from fifteen dolars to fifty dollars.

Your Committee has had several meetings and is making every effort to hold the line. Our final recommendations cannot be made until all the figures are tabulated and our final budget cannot therefore be submitted at this time, but will be ready for presentation to the House of Delegates at their Annual Meeting.

WOMAN'S AUXILIARY

William E. Dodd, M.D., Chairman, Beach Haven

This committee has been active in its advisory capacity during the past year in guiding many of the activities of the Woman's Auxiliary. Under the leadership of Mrs. Lodovico Mancusi-Ungaro the Woman's Auxiliary has stepped further forward into the field of public service than ever before. It has taken its place in the eyes of the public along with other women's organizations which are potent factors in working for the betterment of the people of New Jersey.

The committee approved the plan of activities as submitted by the president of the Woman's Auxiliary for the fiscal year of 1947-1948 which is as follows:

1. Promote friendliness among the wives of physicians.
2. Increase Auxiliary membership.
3. Organize a Woman's Auxiliary in counties where none exist.
4. Assist The Medical Society when requested in any way possible.
5. Promote subscriptions to *Hygeia*.
6. Actively support all health movements endorsed by The Medical Society of New Jersey.
7. Act as a public relations agent in promulgating favorable publicity for physicians through approved channels.
8. Coordinate and integrate the functioning of component auxiliary committees with the corresponding committees of The Medical Society of New Jersey by means of a "work shop day" once a year.
9. See that our members know the stand of all legislators on health questions and that analysis of pending legislation be distributed efficiently.
10. Assume leadership among the women's groups in New Jersey in health education.

The accomplishments of the Woman's Auxiliary have been reported from time to time by the Auxiliary itself, but its activities in the fields of public health and public relations deserve special recognition. "The Round Table Conference on problems of interest to women in the field of health" as outlined in this committee's supplemental report last year was successfully carried out by the Woman's Auxiliary. Three radio broadcasts were presented and were instrumental in bringing the work of the Auxiliary before the public. The "work shop day" brought the Woman's Auxiliary to closer understanding with the various activities and problems of The Medical Society of New Jersey. Out of this developed the part that the Woman's Auxiliary is playing in the school health program. These increased activities of the Auxiliary cost money and a supplemental budget, earmarked for public relations was approved by the Trustees on Sep-

tember 28, 1947. The Trustees charged this committee with the duty of supervising expenditures from this supplemental budget. This we have done after conferring with the Executive Offices of the Society, the Public Relations Committee, and the Officers of the Woman's Auxiliary.

This committee feels that a note of warning should be sounded to members of the Woman's Auxiliary not to become entangled in other organizations in their zeal to work with other interested women's groups.

Chapter X, Section 1, of the By-Laws of the Woman's Auxiliary of the American Medical Association is as follows:

"This Auxiliary shall not affiliate with other federated organizations nor provide for representation on its Board of Directors of representatives of other organizations, nor be itself officially represented on the Board of other organizations."

The same substance, although in slightly different words, is contained in Article IV, Section 2 of the constitution of the Woman's Auxiliary to The Medical Society of New Jersey.

These restrictions may handicap the efforts of the Auxiliary to some extent but as long as they are effective they must be obeyed and the Auxiliary must maintain its individuality.

The committee congratulates the Woman's Auxiliary upon its activities during the past year, and upon the wider recognition of the potential power for good possessed by this organization.

MEDICAL DEFENSE AND INSURANCE

J. Wallace Hurff, M.D., Chairman, Newark

Reports on our Society plan of Accident and Health Insurance indicate a healthy increase. During the period 1947 to 1948 the increase was greater than in the past three years combined. Your committee believes that this is in response to the increase of our indemnity contract from $300 to $400 per month, plus the now active enrollment campaign which will make our contract available to members of our society who did not have the opportunity of subscribing during the first campaign. It is hoped that a more complete report will be available in April.

In reference to our professional liability insurance contract, the final figures covering the year 1947 to 1948 will not be available to this committee before March 15. Our report, therefore, must deal with generalities until these figures can be obtained. Your committee has been active in giving consideration and direction to the many problems that come within its scope of activity.

Our relationships with the United States Fidelity and Guarantee Company and the National Casualty Co. have been those of cooperation and confidence. Upon request, the U. S. F. & G. removed the surcharge on otolaryngologists and ophthalmologists using radium for therapeutic purposes.

Through the cooperation of the insurance committees of the county societies, your chairman has endorsed all applications requiring special hazard coverages such as radium and x-ray therapy, office bed equipment for tonsillectomies, etc.

Upon request, the insurance company has granted increased coverage to several physicians who were formerly limited to minimum basic coverage. Again, upon request, we have made comparative studies of the policies of other companies and forwarded our conclusions to members of our society desiring this information.

In pending suits, we have consulted with the insured and acted as intermediary where there was misunderstanding between the doctor and the insurance company.

Your committee has given much time and consideration to our present procedure of endorsement. Our policy is to endorse that company, which in the judgment of the committee, provided within its contract the best that can be obtained for the purpose for which it is issued. This endorsement, by and with the consent of the Board of Trustees is good for one year.

Your committee feels at liberty at any time to change this endorsement should insurance companies other than those now endorsed, present superior contracts. We urge all members of our Society who desire professional liability, accident or health insurance to support our present program. Should they desire comparative studies of policies of companies other than those endorsed by our Society, your committee will be pleased to supply such information.

POST-GRADUATE EDUCATION

Henry B. Decker, M.D., Chairman, Camden

The Committee met twice during the last year. At the session in March, each county society was requested to send representatives. During this meeting, several matters were discussed which the Committee feels should be brought to the attention of The Medical Society of New Jersey.

1. There is a continuing demand for short series of post-graduate lectures. These lectures meet a demand for recent information, well organized and presented, for which the membership of the society is willing to pay.

2. There is a need for longer lecture courses, planned to review basic sciences and the application of these to clinical problems. These courses require more careful planning, more time, and are more costly. It is felt that such courses should be planned on a bi-ennial or tri-ennial basis rather than the usual annual plan. It is advisable that such series be set up on a regional rather than a county basis.

3. Many of these longer courses are taken by physicians who are preparing for examination by a specialty board. No credit is given by any board for any of these courses. It may be the proper time to suggest that the entire question of qualification for specialty certification be reviewed.

Several of the county societies, cooperating with Rutgers University, set up and operated post-graduate lecture courses during the year. Thanks are due Dean Miller and Professors Chaffee and Light, of Rutgers University, for their cooperation in planning and organizing these courses.

The Rutgers Plan has been in operation for over eighteen months. This is a plan for post-graduate training for general practitioners. Essentially it consists of the attendance of the practitioners at a hospital clinic for one day weekly, for three years. During this period, he rotates through all of the clinics in the out-patient department. Such training rounds out his education in the care of the ambulatory patient and is of value to the hospital staff and to the patient.

This was started on an experimental basis in the Cooper Hospital on October 1, 1946. The five students were selected carefully. The first two have completed the first half of the course.

It was anticipated that certain weak points would develop in any such program. A reorganization of the hospital staff, on a division basis, was necessary. Scientific meetings in each division were required. This was gratifying because it developed that various staff members had scientific and teaching abilities that would otherwise have been lost. It has been of great benefit to the hospital staff.

The students have been helped by the course. They have felt free to criticize the teaching. In every instance it has been constructive.

The hospital has not kept pace with the change. This is due to a number of factors. Chief difficulty is that most dispensaries have developed as appendices to hospitals and the administrators feel, probably with justification, that they are a necessary evil. Changes will be made to improve the dispensary operation. However, such improvements develop slowly.

The Rutgers Plan, so far, is successful in accomplishing its objective and should be extended to other centers throughout the state.

The last matter of this report has to deal with the organization of this Committee. A point has been reached where the Committee, for efficient functioning, must be enlarged. The following suggestions are made:

(1) It is proposed that the name be changed to The Committee on Medical Education.

(2) The Committee should retain its present membership of five. However, each member should be chairman of a subcommittee to which certain specific duties should be assigned. The subcommittees should not be limited as to number of members and the chairman of each subcommittee should have a voice in its membership.

(3) One subcommittee should deal with the development of a medical school in New Jersey, exploring such possibilities and presenting the pertinent data.

(4) Another should deal with the post-graduate lecture courses, as they are now given and as they may be expanded.

(5) Another with the operation and extension of the Rutgers Plan; (6) another with the training of residents and interns and (7) the last with the various requests for courses that do not fall in the previous categories.

PUBLICATION

Henry C. Barkhorn, M.D., Chairman, Newark

The Journal continues to appear with faithful regularity every month, its familiar buff color a friendly reminder to the members of their intimate association with their Society. The Publication Committee has been watchful to maintain a healthy balance between the scientific articles which form the fabric of the educational function of The Journal and the organizational activities which give the periodical its useful "house organ" characteristics. When Dr. Davidson, the editor, accepted a full time position with Veterans Administration it was necessary to make some change in the staffing of The Journal. The Trustees asked Dr. Davidson to continue on a part-time basis at a lower salary and promoted Mrs. Armstrong from Editorial Secretary to Assistant Editor. This was undertaken for a trial period and it has worked out very well. The Committee recommends that the arrangement be continued.

With the employment of a full-time Executive Officer it has been found advisable to place a section of The Journal at the disposal of the Executive Offices to supplement the monthly *News Letter*. This first appeared in the February 1948 issue as "Highlights from Headquarters" and is being continued as "The Bulletin Board".

With the termination of Dr. Yorke's contract with Veterans Administration and the stabilization of the VA program, it has been possible to discontinue the regular monthly "Veterans Care Plan" page; but as our editor is in the VA state headquarters, authorized news of interest to our members from that source has appeared regularly in The Journal.

During the fiscal year, The Journal published 58 scientific articles, covering every specialty in medicine, but slanted toward the needs of the general practitioner. In the aggregate this has constituted a compact postgraduate course for our readers. Organizational activities have been faithfully, fully and promptly reported so that the membership has been kept in close contact with the affairs of the Society. This we believe is the mission of The Journal—a mission which has been successfully accomplished over the year.

ANNUAL MEETING

Harrold A. Murray, M.D., Chairman, Newark

The criteria of success of any convention are based on the attendance at sessions and the interest shown in the exhibits. Your committee, with the able assistance of its two subcommittees, (Scientific Program and Scientific Exhibits) and the Section Officers has diligently planned and arranged a superior program with eminent speakers and exhibits. The results of our combined efforts and the ultimate success of the annual meeting depend on the attendance of the members. We are looking forward to a new high in attendance.

SCIENTIFIC PROGRAM

Francis M. Clarke, M.D., Chairman, New Brunswick

It is with a great deal of satisfaction that the Committee on Scientific Program presents its report in the form of the program for the 182nd Annual Meeting of our society. The program has been enlarged by the creation of additional sections to meet the expanding needs of the profession, and to keep abreast of the many developments occurring in these fields. The officers of the sections are to be congratulated upon their selection of timely topics for consideration, and upon the high order of the essayists and discussants invited to participate. The society is greatly indebted to these officers for their interest and efforts. To the invited guest speakers and to those members of our own society, who by their presentations and discussions make our program possible, the Society extends its thanks.

SCIENTIFIC EXHIBITS

Asher Yaguda, M.D., Chairman, Newark

The Subcommittee on Scientific Exhibits has been fortunate in obtaining 40 exhibits for the 1948 Annual Meeting. Of these, 27 are scientific exhibits shown by New Jersey and out of state physicians. The exhibits cover a wide variety of subjects and bring to doctors attending the meeting a comprehensive summary of many inportant advances in treatment and diagnosis. The remaining exhibits are classed as educational and are sponsored by various local institutions and national agencies. A motion picture theatre will be open daily and ten medical films in color and sound will be shown.

Physicians of New Jersey are urged to attend the Annual Meeting and visit the exhibits which will occupy the Vernon and Garden Rooms at Hotel Haddon Hall.

A list of the exhibits and motion picture films appears on pages 154 and 156 of this Journal.

WELFARE

Vincent P. Butler, M.D., Chairman, Jersey City

The Welfare Committee held four meetings during the year, and these were all well attended. The work of this committee embraces every phase of medical and health matters. The need and usefulness of the committee to the Medical Society becomes more apparent with each change in the current kaleidoscopic medical picture. There is scarcely any problem related to the welfare of the medical profession and the public, that does not come within the scope of the subcommittees or their advisory committees.

Reference to the annual reports of the subcommittees on medical practice, legislation, public health and public relations, together with those of the advisory committees, gives ample evidence of the enormous amount of time and energy expended by the members. No one committee can be singled out, for all proved equally valuable. Each did excellent work in its own particular field.

Among the matters related to medical practice which received attention from the committee under Dr. Herschel S. Murphy were: Laboratory medicine, hospital relationships, hospital manual, nursing and nursing education, and workmen's compensation.

One of the outstanding phases of the work of the Public Health Committee under Dr. Samuel Blaugrund has been the better school health program. In addition to this, they have taken up other related public health matters, such as venereal disease control, cancer, tuberculosis, cardiovascular diseases and crippled children.

The Legislative Committee concerned itself among other things, with undesirable legislation and reported from time to time on its activities in national and state legislation—prominent among which were the compulsory health bills, and in our own state, the consolidation of professional boards.

Under Dr. Sica, the program of Public Relations has been considerably expanded through the medium of radio programs, news releases to local papers and the *Membership News Letter.*

The chairman wishes to express his deep appreciation to all the members of the Welfare Committee for their excellent cooperation.

ALUMNI OF BRITISH MEDICAL SCHOOLS

A New Jersey chapter of the Alumni of British Medical Colleges is now being formed. New Jersey practitioners who were graduated from Scottish or British medical schools are asked to communicate with Dr. W. S. Schram of 52 Liberty Street, Kearny, N. J., for further details.

SUBCOMMITTEES

LEGISLATION

Berthold S. Pollak, M.D., Chairman, Jersey City

Again, of necessity, this will merely be a preliminary report. As this is written the Legislature is about to reconvene, after having been in recess for three weeks. No bills engaging the attention of this committee have yet been adopted. As a matter of fact, only two or three have passed one House.

The major state legislative problem with which we are confronted, and which is causing great concern, is that of the consolidation of the several professional licensing boards and their placement in one of the principal departments of the state government. The provisions of the new Constitution call for the creation of not more than twenty principal departments, and the present plan appears to be to limit the number to fifteen. The Commission on Administrative Reorganization has recommended that the following professional boards of examiners be placed in the Department of State, along with the State Athletic Commission: State Board of Public Accountants, State Board of Architects, State Board of Professional Engineers and Land Surveyors, State Board of Registration and Examination in Dentistry, State Board of Medical Examiners, Board of Nursing, State Board of Optometrists, Board of Pharmacy and the Board of Veterinary Medical Examiners.

Just what connection there is between these nine professional boards and the State Athletic Commission and what prompted the recommendation to place them in the Department of State, we can merely suspect. We have endeavored, with representatives of the other professional societies concerned, to convince the Governor, the Commission on Administrative Reorganization and the appropriate committees of the Senate and Assembly, that the desirable solution would be to group these professional boards into a major department of their own, to be known as the Department of Professional Boards. We have advanced in every direction the argument that disposition of these agencies should be of a character that would not destroy or interfere with the autonomy of the individual boards. As this is written, we are not too sanguine that progress has been made toward the objective of a separate Department of Professional Boards. It may be that the major efforts toward this objective may have to be directed toward the members of the Legislature after formulation and introduction of legislation. There will be hearings on any legislation proposed affecting the various professional boards. At that time, it is hoped that an intensive educational campaign by our Society, and the others interested, may be productive.

Another matter of grave concern is the question of cash sickness benefits. In our last annual report, we mentioned that the bill to create a state-operated cash sickness fund, (introduced at the 1947 session) failed of passage by a narrow margin in the closing hours of the session. A hearing was held, February 25, 1948, on two bills, S-147 and A-28 (referred to as Administration measures), which provide for alternative systems: continuance of voluntary plans and, also, the establishment of a state controlled cash sickness benefit fund. We were represented at this hearing and presented a statement, on behalf of The Medical Society of New Jersey, in opposition to the creation of a state-operated and controlled plan. In our statement, we repeated our adherence to the *principle* of cash sickness benefits, but expressed the view that it would be possible to attain full coverage of all workers in industry through legislation which would make it mandatory for all employers to establish voluntary plans or provide for such benefits, through insurance or otherwise. These were the views and recommendations contained in the Fourth Report of the State Commission on Post-War Economic Welfare released in April 1946.

During the legislative recess, two bills have been dropped in the hopper, A-315 and A-316, which are designed to bring about uniform coverage of cash sickness benefits, in line with our thinking and in accordance with the recommendations of the State Commission on Post-War Economic Welfare in their Fourth Report.

A bill has been introduced, A-255, which would create a board of examiners in "medical technology". This apparently proposes to license a group of laboratory technicians, graduates of short courses, and give them authority completely unwarranted by their educational and technical training.

No bills to permit the examination of graduates of sub-standard medical schools have yet made an appearance, but may still be ex-

pected. So far no bill has been introduced to create a separate board of chiropractic examiners.

On the national scene, our best information is that, from the present outlook, it is very doubtful that either S-1320 (Wagner-Murray-Dingell bill) or S-545 (Taft-Smith-Ball-Donnell bill) will be reported out of committee at this session of the Congress. Pending recommendations of the Hoover Committee on Reorganization of the Executive Department, it appears unlikely that any further action will be taken on S-140 (Fulbright-Taft bill), which would create a Department of Health, Education and Security.

While this is necessarily a sketchy report and perhaps may appear laconic, we can assure the members of the House of Delegates that the intensity and ramifications of the work of this Committee are steadily increasing.

In closing this report it would be incomplete were we not to express our deep appreciation for the fine services that have been rendered by Dr. Quigley. We wish to emphasize the intelligent application of his knowledge concerning matters of legislation which, by reason of his long experience with the members of the respective branches of the Legislature as well as the means of approaching officials connected with health legislation in matters pertaining to federal legislation, has accomplished so much to obtain our objectives.

PUBLIC RELATIONS

L. Samuel Sica, M.D., Chairman, Trenton

Public relations is public service. Therefore, the functions of a medical society in the public relations field begin with the formulation of its basic policies. The bricks and timber of a good public relations structure are the programs of service that are built upon those basic policies.

The job of a public relations committee, *per se,* however, is to interpret the policies and programs of the Society to our members, to our cooperating agencies, and to the general public. This is done through contacts and conferences, through bulletins and publications, through the newspapers and radio, speakers' bureau services, and health educational programs.

CONTACTS AND CONFERENCES

Our Executive Officer has continued the previously established friendly relationships with every organization that takes an interest in health or medical affairs. Through his daily contacts with the e organizations, we and they are reciprocally informed of one another's policies and programs.

The Executive Officer has visited each county medical society at least once during the past six months. These visits will continue, our purpose being constantly to keep the county societies informed of state society activities, to aid the counties in their work, and to bring about a better coordination between county and state activities.

PUBLICATIONS AND BULLETINS

The Public Relations Committee has sponsored the Membership *News-Letter* which has been edited by the Executive Officer and distributed monthly to all members of the Society and to a considerable number of our lay friends. Here again our purpose is to keep our members informed of important activities in the state and to stimulate interest and cooperation in the purposes of the State Society.

We have also recently issued the first of a series of *Quarterly News Bulletins* for lay agencies designed to interpret currently the viewpoint of The Medical Society of New Jersey on matters of general civic interest.

Your committee is preparing the first of a series of pamphlets containing interesting information, attractively presented, to inform the lay public about the health and medical services sponsored by The Medical Society of New Jersey, as well as other community services available to the public. These pamphlets are designed for distribution by physicians in their offices, by pharmacists, school and public libraries, etc.

HEALTH EDUCATIONAL SERVICES

The Medical Society of New Jersey, together with the component county societies, is sponsoring health educational radio programs over the nine principal radio outlets throughout the state. These transcriptions have been prepared by the American Medical Association and are made available without cost through the state and county societies. We express our appreciation to the Woman's Auxiliaries of the several counties for their cooperation in making the necessary arrangements with local

broadcasting stations. We want to thank the radio stations themselves for making the time periods available to us, and the American Medical Association for its part in preparing and distributing these excellent programs.

On the recommendation of your committee, the Board of Trustees has recently approved another radio program series which originates in Providence, Rhode Island, under the title "Doctor's Orders". These programs have been developed by the Council of the New England State Medical Societies and arrangements are being made to have them presented with the endorsement of this Society over several stations in New Jersey. These arrangements provide for commercial sponsorship, except that the type and identity of the commercial sponsor, as well as all announcements on his behalf are to be subject to the specific approval of the Society.

Our health educational service to newspapers in the form of *Health Hints*—a weekly health release—has been placed on a permanent basis under new arrangements that permit these releases to be distributed under the joint sponsorship of the state and county societies in each area. A planned effort will be made this year to stimulate wider use of this service by newspapers throughout the state. The same service is regularly extended to industrial house organs throughout New Jersey.

The Medical Society of New Jersey also prepares and distributes another health news service, known as *Junior Health Hints*, which are sent each week to some sixteen hundred classroom teachers and health education teachers throughout the state. The mailing list for this service is the result of direct requests for this material from supervising principals and teachers in all areas of New Jersey. This provides an ideal medium for our committees on various health and medical topics to present educational material to the schools.

NEWSPAPER STORIES

Special releases have been sent out during the year on many topics, including the four-point school health program, the effect of high food prices on nutritional standards, the action of the Society in regard to state subsidies for voluntary hospitals, and other committee activities of the Society. The program arousing the greatest amount of public interest and the most extensive newspaper coverage so far is the school health program, where, of course, the activity of the Woman's Auxiliary in organizing county school health councils has been a major factor.

PUBLIC HEALTH WEEK

The Public Relations Committee will cooperate with the Public Health Committee in organizing state wide observances of Public Health Week, scheduled for the week of November 8. Governor Driscoll has accepted a request of the Society to designate this period as Public Health Week in New Jersey. A compendium of suggestions and plans for Public Health Week observances has been prepared by the Committee, for distribution to the county societies, to help them in organizing local programs.

THE NEW JERSEY HEALTH CONGRESS

One of the most important public relations activities of The Medical Society of New Jersey during the past two years has been the successful organization of the New Jersey Health Congress, comprising twenty-two professional, official, and lay agencies interested in health services and medical care. The organizing and presiding genius in this matter has been Dr. Stanley Nichols, who serves as the first president of the Congress. Meetings have been held five times a year in Newark, at which time representatives of industry, the farmers, the labor unions, governmental agencies, and the health professions come together to discuss the principal health problems of the State. Although the Congress specifically excludes itself from taking formal action in its own name, it has adopted motions making recommendations to its member agencies on several occasions. It serves as a unique agency for the exchange of views and opinions between a number of varied interests, who at present have no other means of meeting together regularly and exchanging opinions.

COORDINATION WITH COUNTY PUBLIC RELATIONS PROGRAMS

The job of translating the public service programs of The Medical Society of New Jersey into reality on a county and local level requires the utmost cooperation between the county and state societies. These programs generally fall into one or another of three major types: (1) public relations, including public education; (2) public health; (3) medical service, including the extension of the Medical-Surgical Plan and the Medical Service Administration plan for medical care of indigent and near-indigent groups.

Much of our effort in these three fields exists only on paper and can never reach maximum effectiveness until county societies take a hand in putting them into action in the various local communities.

To bring about better cooperation, the Subcommittee on Public Relations will hold an all-day public relations conference on Sunday, May 16, and it hopes that each county society will send its president, its president-elect, and the chairmen of its public relations and public health committees, together with their counterparts in the county woman's auxiliary, to this meeting. The major programs of the State Society will be discussed at that time and methods will be explored for coordinating the work of the county and state societies more effectively.

As a first step in bringing about this greater coordination of effort, the Subcommittee on Public Relations recommends that The Medical Society of New Jersey urge each component county medical society to establish a committee on civic policy with subcommittees on public relations, public health, and medical service. Some of the counties already have an equivalent organization; but if they do not have regularly established committees on public relations, public health, and medical services, the organization of a general committee on civic policy with these three sub-divisions is recommended because there are inevitable inter-relationships between these three fields of work which can best be coordinated if they exist as subcommittees of a general committee on civic policy or the equivalent.

THE WOMAN'S AUXILIARY AND PUBLIC RELATIONS

We commend most heartily the devoted and effective service of the Woman's Auxiliary to The Medical Society of New Jersey and its component county units in assisting the Society in its public relations program — specifically and most notably in promoting the four-point school health program and in arranging with radio stations throughout the state for the broadcasting of our health educational programs. In these and other matters, the Woman's Auxiliary has been most helpful and efficient in promoting the work of The Medical Society. They have demonstrated their right to a prominent part in our public relations program.

PUBLIC HEALTH

Samuel Blaugrund, M.D., Chairman, Trenton

The Public Health Committee during the past two years has operated on the basis that everything pertaining to the public health of our citizens is the direct responsibility of the medical profession. This perspective has been successful and has led to the accomplishment of concrete, constructive programs. The inauguration of "Public Health Week" in 1947 exemplifies this spirit of cooperation among interested groups and is a direct example of the leadership and responsibility that The Medical Society of New Jersey has assumed in presenting to the citizens public health problems that should be met and solved. It is to be hoped that "Public Health Week" will be an annual event for the presentation of factual knowledge to the community at large.

During the past year, in cooperation with the State Department of Education, and spearheaded by the Woman's Auxiliary to The Medical Society of New Jersey, a constructive program for the improvement of school health services is on the verge of accomplishment. It is my pleasure to compliment the president of the Woman's Auxiliary, Mrs. Lodovico Mancusi-Ungaro, and her Public Relations chairman, Mrs. Asher Yaguda, for their untiring efforts and enthusiasm in bringing this school health program into successful operation. It demonstrates that our women have a definite responsibility for carrying out phases of community health which their husbands could not accomplish so well. The Public Health Committee salutes the officers and members of the Woman's Auxiliary for their splendid work during the year. We trust that other important problems will be delegated to them for assistance and accomplishment.

The newborn nursery and the premature baby, long a problem of study and controversy, is now in the way to solution by the recent recommendations of the advisory committee on this subject. These have been presented to the hospitals throughout New Jersey. Solution of this problem will make a tremendous contribution in the reduction of infant mortality in the state.

Within recent months, the Committee on Cardio-Vascular Diseases has participated in establishing a New Jersey Heart Association, composed of both professional and lay groups interested in this problem. Rheumatic heart disease, the number one public health problem in the state and nation, will commence its march toward the reduction (and ultimate elimination) of deaths from this disease.

In cooperation with the State Department of Health, an educational program for the reduction of contagious diseases, (particularly whooping cough) has been recommended and is now on its way to the local level for its consummation.

I wish to highlight the practicability and importance of solving public health problems by consultation between members of The Medical Society of New Jersey, government officials who have a definite public health responsibility, and lay groups having a basic interest in better community health. The Medical Society itself must assume active leadership and responsibility for the program. I take pride and express deep appreciation to my Advisory Committee chairmen and their members for the numerous advances and accomplishments in the field of Public Health in the State of New Jersey during the year 1947-1948.

MEDICAL PRACTICE

Herschel S. Murphy, M.D., Chairman, Roselle

The Subcommittee on Medical Practice held four regular meetings and several special meetings during the year.

The philosophy of the Subcommittee has been that it is our problem to protect the interests of the public and of all the five thousand physicians in our state rather than to advance special interests either in our society or on the part of the public. We feel that the general practitioner is the backbone and mainstay of the practice of medicine and his rights and privileges must be protected.

Our program is not reformulated every year. It has, rather, a distinct continuity about it, because it is rooted in certain fundamental principles which do not change. Let us repeat some of our objectives:

1. In all hospitals, the medical staff should have adequate representation on the Board of Trustees or Board of Directors. This should lead to closer cooperation, an appreciation of the reciprocal responsibilities of both groups, and more effective team-work.

2. Hospital administrators, boards, and physicians should reach some definite agreement as to the classification of patients as "charity" cases, ward cases, private cases and semi-private cases. No physician should be asked to render gratuitous service to patients other than those classified as "charity" cases. Uniform agreement on this would take the edge off many problems now harassing both physicians and hospitals.

3. Responsibility for the care of the medically indigent should be assumed by a cooperative arrangement between government and the medical profession.

4. We recognize that there are segments of our population which cannot secure medical care through their own efforts and resources. We affirm the principle of government subsidies in aiding this limited group—subsidies which, we believe, should represent allotments for specific purposes, disbursed by specified agencies; provided always that there be no government control or political regimentation of physicians rendering such services. It is as much a function of government to aid in the restoration of health and cure of sickness for those of its needy citizens, as it is the duty of the physician to render his best efforts and services to achieve this end. It is, however, not right for the physician to assume the burden for these cases, without the cooperation of government aid.

The Advisory Committees have done their work well and we refer you to their reports for the detailed story of activities of each Advisory Committee. However, I should mention a few highlights of the year:

The Committee on Radiology is carrying out the request of the Board of Trustees for the study of exploitation of radiologists, pathologists, anesthesiologists and physiotherapists by hospitals. It made a survey of all the radiologists of the state. The committee has also urged the listing of specialists in the classified section of the telephone book.

The Committee on Physical Medicine has studied the program of Crippled Children's Commission clinics for cerebral palsy and the program of the National Society for Crippled Children and Adults which is seeking to establish a chapter in New Jersey.

Among its problems, the Committee on Industrial Health and Hygiene studied the proposed Industrial Health Clinic to be located at Belleville.

The Committee on Nursing and Nursing Education studied the proposed standards for the training of practical nurses in New Jersey and recommended certain constructive changes.

The Workmen's Compensation Committee has worked with the Compensation Insurance Companies to secure state-wide approval of the increase in compensation fees.

The *Manual of Standards for Private Hos-*

pitals in New Jersey, prepared by the Department of Institutions and Agencies was studied by our Committee and constructive changes and suggestions were made.

Our Committee as a whole, has worked to secure the cooperation and approval of the life insurance companies for a standard fee of ten dollars for regular life insurance examinations with a proportionate increase for all other examinations and life insurance reports. While some of the life insurance companies are favorable, additional work must be done in order to have all agree. We recommend that our delegates to the next session of the House of Delegates of the American Medical Association be instructed to take this matter up with them and secure their approval. Having the American Medical Association communicate with all the life insurance companies on a nation-wide level would be most helpful.

PUBLIC HEALTH ADVISORY COMMITTEES

CANCER CONTROL

William O. Wuester, M.D., Chairman, Hillside

The work of this Advisory Committee has grown in quantitative progression this year. In the interests of more complete geographic representation, the Committee added to its regular membership, Dr. Frank W. Konzelman of Atlantic City, and Dr. John Faison of Jersey City. Dr. Raymond V. Brokaw has been added as a consultant member.

Projects totalling some $250,000 have been presented to the Committee and $120,167.36 worth have been approved and processed for the counties.

A plan and schedule of specific benefits payable to cancer clinics was evolved by the Committee; this was approved by the Board of Trustees, Medical Society of New Jersey. This plan is now in process of publication in The Journal, and is intended as a measure of assistance to cancer clinics in general hospitals in their effort to continue their solvency and as a means of avoiding financial liability to the hospital administration. The Committee feels that this is an important step in complementing present cancer activities in New Jersey.

The Committee authorized the publication of a reference list of physicians who have signified their willingness to conduct complete health maintenance examinations on prior appointment as part of their office procedure. The general practitioner is the backbone of the cancer detection program in this state. Every effort is being made to develop the cancer diagnostic clinic into a specific center of technical assistance to the general practitioner.

After some eighteen months of negotiation and discussion of the cancer program in the Mountainside Hospital, the Committee was authorized to approve the present organization known as the "Examining Clinic for Cancer Diagnosis" at the Mountainside Hospital. The responsibility for medical supervision of this experimental clinic is in the hands of the medical board and medical staff of the Mountainside Hospital.

As this program year draws to a close your Committee has organized a postgraduate seminar on cancer for general practitioners to be held on March 31, 1948, at the Academy of Medicine in Newark, New Jersey.

The statewide tissue diagnostic service is being extended to benefit dental surgeons practicing in New Jersey. They will be circularized before the end of the fiscal year, as were the physicians last year.

Members of the Cancer Committee of each county medical society will receive bound copies of the New Jersey Cancer Bulletin published as a cooperative project with the American Cancer Society, New Jersey Division, Inc. If this proves sufficiently useful, it will be distributed to physicians conducting complete health maintenance examinations.

The cooperating cancer clinics are faithfully submitting reports and data on patients seen in cancer clinics. These will be analyzed statistically in the very near future. Tables of organization in the cancer clinics are gradually being assembled and a more complete picture of the activities of each clinic is being crystallized.

MEDICAL PROJECTS APPROVED TO DATE

Up to March 1, 1948, the committee approved the expenditure of $120,167.36 of

American Cancer Society funds for medical projects in New Jersey. The allotments by counties follow:

Atlantic County	$ 4,842.00
Bergen County	9,600.00
Cumberland County	3,000.00
Essex County	33,328.95
Hudson County	9,835.85
Hunterdon County	2,400.00
Middlesex County	2,500.00
Monmouth County	6,837.21
Morris County	7,644.70
Passaic County	30,460.25
Salem County	4,142.47
Union County	5,489.85
Warren County	86.08

CARDIO-VASCULAR DISEASES

Jerome G. Kaufman, M.D., Chairman, Newark

The Committee is in agreement that there is a serious shortage of approved facilities for the care of cardiac patients in the state; that in order to increase the interest of the medical profession and the laity in cardiac diseases greater publicity is needed, and that a program for increased education of physicians, nurses, social workers and teachers, must be initiated. This would require the expenditure of large sums of money. Since no funds are available for such purposes, it was decided that a New Jersey Heart Association be founded. This is to be part of the American Heart Association, and its Board of Directors is to include outstanding physicians and laymen.

The New Jersey Heart Association's policies and tentative program were presented at the December meeting of the Subcommittee on Public Health, and were published on pages 36 and 37 of the January 1948 Journal. The principles were endorsed by the Board of Trustees of The Medical Society of New Jersey.

Through the efforts of the Committee several new heart clinics have been established in various parts of the state, and it is hoped that, as the need is felt in other communities, new clinics will be organized.

This is the beginning of a real awakening, by the medical profession of New Jersey, for the study and care of cardio-vascular diseases, which are responsible for one out of every three deaths.

CHILD HEALTH

Stanley Nichols, M.D., Chairman, Long Branch

Much progress has been made during the past year on the Medical Society five point long range program of the outstanding needed improvements in the child health field in New Jersey. These five points are:

(1) An improved school health program.
(2) A program for the improvement of neonatal mortality.
(3) Rheumatic heart disease control. This is the greatest single cause of death in school children, except accidents.
(4) A sound mental hygiene program for children.
(5) Better medical care for children in low income families.

IMPROVEMENT IN SCHOOL HEALTH PROGRAM

The program for bringing New Jersey's school services up to date has made great strides during the year and is receiving nation-wide attention. The joint four point program, set up by the cooperation of the New Jersey State Department of Education and The Medical Society of New Jersey last year, is being translated into action at county and local school system levels by the excellent work of our Woman's Auxiliary.

At the request of President Schaaf and the State Society, the chairman of the Child Health Committee represented our Society at the first national conference held by the American Medical Association on "The Cooperation of the Physician in the School Health Program", at Highland Park, Illinois in October, 1947. This conference was very successful and set up a program for the improvement of school health services. Recognition was given to our New Jersey prior program at state, county and local levels.

Our Society should take great pride in the fact that it is being recognized nationally that our Society is far advanced on many needed health and medical care programs in the public interest. Our active cooperation through the years with public and private health agencies; our veterans medical care program; our voluntary medical insurance programs, and now our school health programs, together with many others, are a great credit to the willingness of the five thousand members of this Society to evidence real helpfulness in meeting *all* of the health and medical care problems of the present age.

NEONATAL MORTALITY

Dr. Brown's Subcommittee on the Newborn, working with Dr. MacKenzie's Maternal Welfare Committee, and the Bureau of Maternal and Child Health of the State Health Department, guided by Dr. Julius Levy, are making steady progress in improving newborn and premature care in New Jersey's hospitals.

RHEUMATIC HEART DISEASE CONTROL

The major project of Dr. Blaugrund's Subcommittee on Public Health for the year has been a state wide attack on the cardiovascular disease entities. A full report by Dr. Jerome Kaufman is found on page 186.

MENTAL HYGIENE PROGRAM FOR CHILDREN

Dr. Edward P. Duffy, Jr., Chairman of our Subcommittee on Mental Health, with the aid of consultants Dr. Henry Cotton, Jr., and Dr. G. W. Esty, have begun an educational program in several places. These are being expanded by the program of mental health education for the nurses and physicians attending the "Baby-Keep-Well Stations" of the State Department of Health. Further expansion is coming about as the result of the gradual development of the mental health program under the chairmanship of Dr. Henry Cotton. The Child Guidance Clinics developed by the State Department of Institutions and Agencies, and those in some of our large cities, are of great importance in this much needed expansion of better mental health training for children and their parents. Dr. Cotton is planning new developments in this difficult field, which will be financed in part by New Jersey's share of the federal funds now available for mental health research and treatment.

CHILDREN IN LOW INCOME FAMILIES

This is the paramount problem facing the medical profession today, and two important developments have occurred during the year. First, the New Jersey Health Congress, (sponsored by the Public Relations Committee of our Society), has been holding regular conferences with the three component groups: (1) the health professions *rendering* services, (2) the main groups *receiving* health services, and (3) the state governmental agencies interested in health services for joint study of quality, quantity, availability, and distribution of professional health services in New Jersey. Inasmuch as children in low income families have greater need of medical, dental, nursing, pharmaceutical, and hospital care, the recommendations of the Congress should receive the support of every member of The Medical Society of New Jersey.

Important too in this connection, is the completion of the million dollar survey of child health by the American Academy of Pediatrics. The New Jersey material will be studied by the State Academy Fellows, under the leadership of Drs. Harrold Murray and Fred Lathrop, and recommendations for improvement of child health in New Jersey will be made available to all interested agencies. In proportion as the child health needs shown by this survey are met by *voluntary* effort at a county level, under the leadership of each county medical society, the need for *governmental medicine* for these children in low income families will be diminished.

Fortunately for New Jersey, the Academy National Committee for the Improvement of Child Health of the American Academy of Pediatrics is to set up its headquarters in Philadelphia. The job of this Committee is to promote the solution of the child health needs revealed in the national survey. The Academy has set up an excellent staff with a budget of seventy-five thousand dollars a year to carry out this program and the support of the American Medical Association, the U. S. Public Health Service, the Children's Bureau, the National Foundation for Infantile Paralysis, and many other voluntary agencies, who contributed the million dollars, will be squarely behind this *voluntary* effort to promote better child health in this country. This setup nearby will be of great assistance to those of us in New Jersey who have been working together for many years to make New Jersey the "child healthiest" state in the union.

The Child Health Committee recommends that the following resolution be adopted by the House of Delegates of The Medical Society of New Jersey and presented by our delegates to the House of Delegates of the American Medical Association in June, 1948:

Whereas, the American Medical Association held the first national School Health Conference in October, 1947, and included in its third Rural Health Conference in February, 1948, the health and medical care problems of rural children and

Whereas, state and county medical societies, having child health committees and programs, have need of guidance and assistance at national levels for their child health programs by having a specific bureau of the American Medical Association responsible for children,

Therefore Be It Resolved, that The Medical Society of New Jersey request that the House of Delegates of the American Medical Association add the words "Child Health" to the title of the present Bureau of Health Education, to read "The Bureau of Child Health and Health Education", in order that this excellent and helpful Bureau may be regarded by county and state medical societies as a coordinating center for the study and evaluation of the many types of child health and medical care programs being evolved by governmental, medical, and voluntary agencies in this country.

CONSERVATION OF VISION AND HEARING

Elbert S. Sherman, M.D., Chairman, Newark

Early in December the president of the New Jersey Optometric Association wrote to The Medical Society of New Jersey, inviting "the collaboration and support of The Medical Society of New Jersey in its efforts to abolish the commercial and advertising refractionists". The communication was referred to our committee.

After considerable correspondence with the officers of the Optometric Association and failure to obtain any specific information concerning their plans and the proposed legislation, we invited their officers to attend a meeting. Three of them accepted the invitation and told us then that they had prepared a bill, intended to amend the Optometry Act, to be introduced in the Legislature for which they desired the support of the New Jersey Medical Society. They agreed to send to each member of our committee a copy of the bill. As we have not yet received the copy, we cannot make any recommendations.

Last September the Motor Vehicle Department asked the Medical Society to assign an ophthalmologist to give talks to the Department's inspectors. This chore was kindly taken over by Dr. Irvin Levy, who gave four very satisfactory talks on the importance of the eyes in driving. Dr. Levy also represented the committee at the recent meeting of the Pan-American Ophthalmological Congress in Havana.

Dr. R. W. terKuile of our committee has been active in Bergen County concerning conservation of vision in school children.

CRIPPLED CHILDREN

H. Eugene Reading, M.D., Chairman, Paterson

Your committee outlined a long range program of coordinating its activities, in an advisory capacity, with the various organizations in New Jersey interested in the crippled child. Results of the several meetings with three of the important agencies in New Jersey have been both pleasant and fruitful.

A meeting was held last October with executives of the National Foundation for Infantile Paralysis. There was free discussion of the problems affecting the poliomyelitis patient in New Jersey, especially the lack of uniform policies of the various county chapters of the Foundation, prior to Mr. Bowens' appointment as State Representative. Mr. Bowen graciously proposed the formation of a Professional Advisory Committee to include among others, a member of the Crippled Children Committee of The Medical Society of New Jersey, a representative of the Nursing profession of New Jersey and of the New Jersey chapter of the American Physical Therapy Association.

A combined meeting of the Crippled Children Committee and members of the Crippled Children Commission of New Jersey was held in December. One function of this meeting was to discuss the cerebral palsy units. There have been misunderstandings on the part of orthopedic surgeons in New Jersey as to the need and function of the newly opened Cerebral Palsy Units in this state. The members

of both Committees, the several State Medical Society Chairmen and Officers, as well as the guests were called on to speak. Dr. Phelps reviewed the program of treatment for Cerebral Palsy patients in New Jersey dating back to 1936. He defined the new Cerebral Palsy Units in New Jersey as "Physical Re-education Units", preferably located within the elementary school buildings which should be accepted by the Board of Education as part of the state education program. Medical care for these patients would continue uninterruptedly by the family's choice of physician or hospital clinic. Patients referred by physicians will be accepted at these Units.

At the conclusion of this meeting it was felt that the previous misunderstandings were cleared up. The establishment of the Cerebral Palsy Units as "Physical Re-education Units" sponsored by the Crippled Children Commission of New Jersey were therefore acceptable to the Advisory Committee on Crippled Children.

The New Jersey Chapter of the National Society for Crippled Children and Adults was duly incorporated as a Unit for the State of New Jersey on January 14, 1948. The chapter did not feel it can accept the $10,000 offered by the New Jersey Federation of Junior Women's Clubs until a concrete program is formulated which will be acceptable to The Medical Society of New Jersey.

Facilities for occupational therapy and speech therapy are woefully lacking in New Jersey. There is not, at this time, any workable program for rehabilitation of the handicapped adolescent under the age of sixteen.

The National Society would fill a long felt need in undertaking a program of the above functions.

The designation of "Curative Workshops" has been used by many of the established state and local chapters of the National Society and properly so. If this name is to be used, direct medical supervision will be necessary. The alternative at least for the present, might be the designation of "Workshops" of the National Society,—for occupational therapy and rehabilitation. Furthermore, if at all possible, affiliation should be sought with local hospitals if space is available within the hospital buildings. The "Workshops" should be located near enough to hospitals so as to take advantage of professional assistance or medical supervision of the hospital physicians in the various specialties.

The New Jersey Committee of the National Society for Crippled Children and Adults assured our Committee that immediate surveys of existing facilities and community needs will be undertaken for the location of "Workshops", possibly starting in South Jersey, and a definitive program will then be submitted to The Medical Society of New Jersey for approval or suggested changes.

MATERNAL WELFARE

Robert A. MacKenzie, M.D., Chairman, Asbury Park

The Committee met in July at the home of the Chairman to plan activities with particular reference to the December meeting with the field physicians, upon whose efforts this Committee depends so much.

At the December meeting, eleven of the twelve appointed field physicians were present, along with representatives of the Division of Maternal and Child Health of the State Department of Health, of which organization they are a part. Also present were interested doctors from many of the component county medical societies. There was valuable discussion of ways to improve the level of obstetrical practices throughout the state and to utilize the excellent statistical and other services of the Division of Maternal and Child Health. Each field physician was given an opportunity to discuss the problems which he encounters in investigating maternal deaths and in other aspects of his work. Several constructive suggestions were made, especially with reference to the creation of reserves of blood including Rh negative blood for emergency transfusions. Many of those in attendance participated also in the evening program of the Section on Obstetrics and Gynecology at the Academy of Medicine of Northern New Jersey. At this meeting, the Chairman of this Committee was one of the discussors of the paper on Benign Pelvic Tumors and spoke of the significance of these tumors as a complication of pregnancy.

In the last annual report mention was made

of the formation of the New Jersey Obstetrical and Gynecologic Society, sponsored by this Committee. There has been an enthusiastic response by the members of our state Medical Society to the opportunity which this special society offers. Nearly two hundred members have been enrolled and the first clinical all-day meeting held at the Margaret Hague Hospital in November had a remarkable attendance of nearly the same number. There will be a spring meeting of this group and, as a part of the program, the Chairman of this Committee will present a report on maternal deaths in New Jersey during the past two years and invite discussion of factors contributing to these fatalities, some of which unfortunately must still be listed as preventable.

Concerning the personnel of the Committee on Maternal Welfare, it may be interesting to remark the addition of three young members, whose particular interest in maternal welfare work is highly valued and most welcome. They are Dr. Richard F. Tomec, Dr. Edward N. Comando and Dr. Joseph E. Mott. Dr. John D. Preece, another of the younger group in practice, appointed to this Committee in 1946, has been named Executive Secretary of this Committee, with the special assignment of close cooperation with our Consultant, Dr. Levy, and the Division of Maternal and Child Health, in immediate review of maternal death reports.

The Chairman attended a meeting of the Child Health Committee of Essex County in January and participated in a comparative analysis of stillbirths and neonatal deaths in Essex County hospitals. Responsibility for fetal loss being largely upon the obstetrician, this Committee will continue to be interested and will try to be helpful in improving obstetrical results, including the salvage of some babies now lost through imperfect management of labor or delivery.

A summary of statistical reports of obstetrical work in New Jersey hospitals—maternal deaths included—will be offered for publication in an early issue of the Journal.

MENTAL HYGIENE

Henry A. Cotton, Jr., M.D., Chairman, Trenton

Two meetings of the committee were held during 1947. We felt that there was a need for continuing the educational program for general practitioners in the field of psychiatry and mental hygiene along the lines of the courses given in Essex County last year. The committee has been studying the possibility of setting up refresher courses in some of the larger counties. While it was impossible to hold these during the present year, it is hoped that several may be organized in 1948.

As a result of recommendations made by the Committee last year, most of the county societies devoted at least one meeting during 1947 to the subject of psychiatry.

The question of the care and treatment of alcoholics in New Jersey was carefully studied. The committee felt that there was a need for institutional facilities in which alcoholics could receive relatively long-term care along mental hygiene lines. We re-emphasized a previous recommendation that there should be legal authority for the commitment of chronic alcoholics regardless of whether they are psychotic. A subcommittee consisting of Drs. English, Wallis and Tenney studied this situation.

The problem of the psychopathic personality or defective delinquent received attention. The committee was concerned over the fact that there is a considerable group of these cases which constitute a definite hazard to their communities. Furthermore, under existing legislation, most of them can be held in correctional institutions for only a short time, after which they must be returned to the community. Since they are not psychotic, they cannot be kept in state hospitals. Legislation should be drafted to provide for institutionalization and treatment of defective delinquents.

The committee has studied the present form of commitment to mental hospitals and feels that it is inadequate. The term "insanity" is undesirable and should be replaced by "mental illness". The requirement of certification by two physicians plus a court order sometimes causes delay in admission of emergency cases. It was felt that, in addition to the regular commitment (signed by two physicians and including a court order) there should be an emergency form of commitment requiring the signature of only one physician. This "emergency commitment" would enable the superinten-

dent of a mental hospital to hold the patient for a period of not more than ten days, at the end of which time, the patient would either be discharged or committed in the regular manner. Legislation should also be drafted providing for some agency (police or health authorities) to transport the patient to the hospital. This transportation would be on the basis of the doctor's certificate plus the concurrence of the family and would not require further legal action. Theoretically, this might make it possible for normal persons to be "railroaded" into mental institutions but in practice this would not happen. Mental institutions in New Jersey, both public and private, are operated on a high professional level and any patient whose condition does not warrant institutionalization would undoubtedly be discharged in very short time. Dr. Cotton is to work with representatives of the Attorney General's Office to explore the possibility of drafting such legislation and, if it appears feasible, the matter will be referred to the Legislative Committee of The Medical Society of New Jersey.

The recommendation by the New Jersey State Association of Psychologists to license and regulate the practice of clinical psychologists was considered. While such legislation is probably desirable, it should receive further study, not only by this committee but also by the societies as a whole.

The Committee is gratified to note that at the 1948 Annual Meeting, there will be a separate section on Neuropsychiatry on the same basis as the other medical specialities. This constitutes a distinct step forward in the progress of mental hygiene and psychiatry and the committee wishes to express its thanks to the President and Board of Trustees for making this possible. An unusually attractive program has been arranged.

NUTRITION

S. William Kalb, M.D., Chairman, Newark

The Nutrition Committee has made speakers available to many component societies and auxiliaries. We have cooperated with a large group of lay organizations in helping them formulate programs on nutrition.

An exhibit on nutrition will be presented at the Annual Meeting in Atlantic City. We are also contemplating a graduate course of six lectures in nutrition to be held at various centers in the state.

SCHOOL HEALTH

Harold F. Tidwell, M.D., Chairman, West New York

The first objective of the Committee on School Health was met when the Four-Point Basic Program was approved by The Medical Society and by the State Board of Education. Our second objective, of necessity, was to get the plan in operation in the schools of the state. Last June, at the suggestion of Dr. Wilson G. Guthrie, (Director of Health, Safety and Physical Education of the State Department of Education) the Woman's Auxiliary agreed to implement the Four-Point Program at a county level. The project has been made the primary objective of the Auxiliary this year and the task of organizing the county units was assigned to Mrs. Yaguda, Chairman of the Public Relations Committee. Under her able guidance, councils have been formed and are working in eleven of the fourteen counties which have auxiliaries. Plans are progressing satisfactorily to organize auxiliaries in the seven remaining counties and it is hoped that in six months, the whole state will be organized.

The Consulting Committee held a meeting which was attended by Dr. Schaaf, Commissioner Bosshart and representatives of the State Teachers Association, the Parent-Teachers Association, and others interested in improving school health. Enthusiastic support was promised by all of the groups.

TROPICAL DISEASES

Christian P. Segard, M.D., Chairman, Leonia

During the year the Committee prepared a report on the current new activities in the field of tropical diseases. We have found that the VA, the Army, the Navy and other divisions of government medical services that note the appearance of tropical disease among personnel have taken excellent care of them. This has prevented in a very large measure the appearance of tropical disease in the offices of civilian practitioners.

TUBERCULOSIS

Abraham E. Jaffin, M.D., Chairman, Jersey City

The Advisory Committee on Tuberculosis took up two important subjects as the main topics for the past year. They first dealt with the desirability of x-raying patients admitted to all hospitals in accordance with the recommendation of the American Hospital Association, U. S. Public Health Service and National Tuberculosis Association. The committee felt that we should recommend chest x-ray screening of all hospital and clinic patients as a routine public health measure.

The other subject dealt with measures to increase the role of the general practitioner and private physician in case finding. The private physician is the greatest source of referring cases to the diagnostic chest clinic. This plan might be encouraged by providing x-ray facilities for any physician without making the patient a "clinic case". The success of this in Somerset County justifies its adoption particularly in counties that have no established tuberculosis services. It was recommended that The Medical Society of New Jersey in cooperation with the Tuberculosis League, request Drs. Doppler and Douglass, together with Mr. Bryan, to visit selected counties to recommend to their county medical societies that physicians be urged to send their patients for chest x-rays at any time in accordance with the Somerset Plan. The Board of Trustees at its meeting in January, approved this recommendation and the committee hopes that this will be put into effect and that the results will be fruitful.

Tuberculosis Abstracts are issued monthly by the National Tuberculosis Association and are made an integral part of The Journal of The Medical Society of New Jersey. They offer, in effect, a postgraduate course in tuberculosis. They are concise, practical, and can play an important role in making every doctor not only chest x-ray conscious, but more tuberculosis conscious. These should be called to the attention of the readers from time to time.

In closing I wish to say as chairman, that I was again most fortunate in having the cooperation of a group of men who, in experience and personality, represent the best thought in tuberculosis. There are many problems arising in connection with newer developments, particularly in therapy. While the committee does not wish to leave the impression that it knows the last word on these matters, it nevertheless realizes that if its function is to be advisory, it should be ready and prepared to give whatever advice it can when sought. In analysing the present case finding situation, I wish to express my gratitude to Dr. Doppler and Dr. Hughes for their kind and valuable cooperation.

VENEREAL DISEASE CONTROL

Robert L. McKiernan, M.D., Chairman, New Brunswick

The Committee has had a busy year and has worked out a dynamic and vigorous program, the principal features of which are the following:

1. There are inadequacies in the handling of quantitative serologic testing for reagin. Such facilities are indispensable in modern venereal disease treatment. We urge the State

Department of Health to expand its facilities in this field. We ask the State Department of Health also to seek funds enough to permit the adequate and free distribution of penicillin in oil and beeswax for the treatment of patients having acute or infectious forms of gonorrhea or syphilis, provided, that in the opinion of the treating doctor, the patient cannot afford to pay for these drugs.

2. The teaching of all phases of human hygiene is a basic pedagogic necessity. It is specifically, part of the program against juvenile delinquency. The prevalence of syphilis among juvenile delinquents is very great. The committee is prepared with printed matter outlining an approach to the problem, presenting the factual content needed by teachers, and suggesting a correlated program by integration of the data into many subjects now in the school curriculum. In general, the schools should give courses in human relations and education for family life.

3. The construction of race tracks in New Jersey has brought us a fluctuating migrant population with a high venereal disease rate. We commend the cooperation given in meeting this problem, by the Division of Venereal Disease Control and by the track managements. Not entirely solved is the question: who is responsible for the care of these migrants?

4. An unusually fine program has been scheduled for the Venereal Disease Section at the Annual Meeting this year. Our speakers, Dr. Norman Ingraham and Dr. John Stokes are both nationally known and their subjects are timely, instructive and challenging to all of us.

MEDICAL PRACTICE ADVISORY COMMITTEES

ANESTHESIOLOGY

H. G. Walker, M.D., Chairman, Wyckoff

The Advisory Committee on Anesthesiology, speaking on behalf of the professional medical anesthetists of the State, hereby expresses its appreciation to The Medical Society of New Jersey for its creation of a scientific section on anesthesiology.

During the past year the committee on anesthesiology has given consideration to the two following pertinent matters dealing with the practice of anesthesia:

1. The growing institutional commercialism of the practice of anesthesiology which, if continued, will lead to a deterioration and lack of scientific advancement in anesthetic services.

2. The fixed fee schedule of the Medical-Surgical Plan for anesthetic services. In some instances, the fee as established covers the service rendered. In many other cases, this rigidly fixed fee is entirely inadequate. No provision has been made covering the time duration of the anesthetic, the pre-anesthetic work up or the post-anesthetic special care by the anesthetist.

It is thought by the Committee that the two following suggestions might go far in correcting the two above faults.

1. That directives again be forwarded to the responsible heads of all institutions informing them that the practice of anesthesia has been adjudged by the American Medical Association to constitute the practice of medicine. The same stand has been taken by The Medical Society of New Jersey.

2. That the Directors of the Medical-Surgical Plan consult with the incoming members of the Advisory Committee on Anesthesia so that, if possible, a revised fee schedule dealing with anesthesia may be adopted which will be satisfactory to all parties concerned.

The members of the Advisory Committee have considered it an honor and a privilege to have served for the past year. We are aware that the interest of The Medical Society of New Jersey in anesthesiology has already improved the quality of anesthesia as practiced throughout the state.

CONTRACT PRACTICE

Andrew C. Ruoff, M.D., Chairman, Union City

The Contract Practice Committee has had no matters referred to it specifically, during the year. This Committee functions only when matters purely of a contractural relationship, present themselves. Its Chairman has attended several meetings of the Subcommittee on Medical Practice. Several broad matters of contract practice have been presented to the Subcommitee on Medical Practice, and these have been of a character that could well affect the future practice of medicine. It was on this account that the matters were referred to the Subcommittee on Medical Practice, rather than to this Committee.

HOSPITAL RELATIONSHIPS

Earl H. Snavely, M.D., Chairman, Newark

We had referred to us the question of a fee being paid for each private patient admitted by the doctors on the staffs of hospitals. The Committee disapproved of any fixed fee, but agreed to allow the hospital to accept voluntary contributions until the question was settled by the Subcommittee on Medical Practice and the Welfare Committee. At that time the Welfare Committee agreed that it was a bad practice to have doctors pay a fee to the hospital, either on a voluntary or compulsory basis. The request was therefore disapproved.

The Standards to Decrease Neonatal Mortality were approved by the Committee, and adopted by the Subcommittee on Medical Practice, and have now been sent to all members of the Medical Society as well as to the hospitals.

The Hospital Relationships Committee was opposed to establishing a Belleville industrial health program. We were interested in the practical nurse program, and the Chairman sat in with the Committee as a whole when these discussions took place, and was in favor of the final action taken.

The intern training and educational program was not referred to our Committee. The only unfinished business in the hands of the Committee is a letter from the Department of Health of Union City in reference to the reopening of Union City General Hospital.

INDUSTRIAL HEALTH AND HYGIENE

J. Mallory Carlisle, M.D., Chairman, Westfield

The Chairman of the Advisory Committee on Industrial Health and Hygiene has continued to represent this group at regular meetings of the Subcommittee on Medical Practice. Many routine matters bearing on industrial practice have been cleared with the Subcommittee.

During the past year, an important problem came up, one that is exemplified by the so-called "Belleville Plan". This program for industrial health was prepared by Dr. Leonard J. Goldwater and Dr. Irving R. Tabershaw and presented to the Belleville Foundation, a group of persons connected with industry in the Belleville area. The program would create a special clinic in Belleville for industrial health services. It would have a full-time Medical Director and would be staffed, in part, by persons taking graduate work in this specialty. A charge was to be made to each contributing industry on the basis of the number of employees. The work of the clinic was to include care of occupational illnesses and injuries, advice to industry on health matters, supervision of plant sanitation, job analyses, and periodic supervision of the health of the workers.

Dr. Goldwater requested the approval of The Medical Society of New Jersey for this project and it was placed on the agenda of the Subcommittee on Medical Practice in November 1947. At that time, however, inadequate

data were available to permit the Subcommittee to give any clear-cut expression either of approval or disapproval. It was later learned that the physicians of the Belleville area disapproved of the proposed clinic and that they planned to survey the needs of the community from the industrial health point of view and to determine the facilities available for meeting them. The chairman of this Committee then attended a meeting of the Belleville physicians at which objections to the plan were clarified and ways of carrying out the proposed survey were discussed. It was felt that the plan proposed by Dr. Goldwater was impractical financially unless subsidized, that it was an experiment tending towards socialized medicine and that work of this sort should be carried out by the local physicians who are interested and capable in the field. A letter to industrial organizations in Belleville was drafted which was to be sent by the physicians in Belleville. This would offer the industries a survey of their medical needs, with the intention of translating these needs into practical plans of procedure for rendering effective industrial medical service. It is hoped that with this stimulus real progress can be made towards meeting the most difficult problem now confronting us in industrial medicine, namely, the care of the worker in the smaller industry.

Your Committee has continued its activities in the various national groups devoted to the study of occupational medicine and the protection of the health of the worker. These include the American Association of Industrial Physicians and Surgeons and the American Academy of Occupational Medicine, as well as other groups which may touch in part the problems of industrial health, such as the National Tuberculosis Association.

LABORATORY MEDICINE

Asher Yaguda, M.D., Chairman, Newark

This has been a year of many changes. Some old problems have been solved only to be replaced by new and more urgent demands for vigilance and action. The world is uneasy and everyone appears to be jockeying for position and advantage. Many attempts are being made, under innocent and apparently innocuous guises, to open the door to some form of state medicine and corporate practice. Fortunately The Medical Society of New Jersey is alert to these dangers and, in some measure at least has erected a bulwark against their rapid advance.

The Advisory Committee on Laboratory Medicine has made some progress this year in obtaining recognition of the specialty which it represents. The creation of a section on Clinical Pathology within The Medical Society is concrete evidence that pathologists have, at long last, been accepted as practitioners of a medical specialty. The program of our first scientific session to be held as a section of The Medical Society reflects our desire to operate for the benefit of the entire medical profession.

Some progress has also been recorded in our endeavor to get legal recognition of our status as practitioners of a specialty within the practice of medicine. The legislative committee, through Dr. Quigley, arranged a meeting in Newark last October, which was attended by representatives of the Board of Medical Examiners, the Legislative Committee of The Medical Society, The Advisory Committees on Radiology and Laboratory Medicine, and the Medical Practice Committee. After thorough exploration of the questions involved it was the opinion of this group that the objectives of The Medical Society could be accomplished by amending Section 45:9-18 entitled "Who regarded as practitioners" by adding in the appropriate place in this section the words "or who shall offer or undertake any means or methods which are designed to be used for the purpose of diagnosis or treatment of disease, pain, injury, deformity or physical condition". In order not to interfere with the legal employment of technologists in the fields of roentgenology, laboratory medicine and anesthesiology, the following exception was recommended under section 45:9-21 entitled "certain persons and practices excepted from operation of the chapter." "Technologists in roentgenology, clinical pathology and anesthesiology working under the direct supervision of a qualified medical practitioner." This matter is now in the hands of the Legislative Committee for action at a suitable time.

Further evidence of the urgent need for the passage of an amendment to the Medical Practice Act incorporating radiology, clinical pathology and anesthesiology into the practice of medicine is seen in the most recent attempt by a group working on the fringe of medical practice to hew out for themselves and exempt

from the provisions of the Medical Practice Act a field of endeavor which has been acknowledged by the American Medical Association and The Medical Society of New Jersey to be a Specialty of the Practice of Medicine. I am referring to Assembly Bill A-255 which creates a Board of Examiners in Medical Technology and whose provisions would exempt medical technologists from the regulatory provisions of the Medical Practice Act. This would be a nullification of the Medical Practice Act. The Medical Society of New Jersey has recorded its disapproval of this measure and it is to be hoped that the bill will fail to pass.

One of the most potent threats against private practice is the advancing front of corporate practice of medicine. Through lack of forethought and clear vision of future trends, the medical profession itself has introduced and allowed to flourish and expand a form of practice which now threatens to destroy its creators. The Medical Society of New Jersey has recognized and spoken out forthrightly against this practice. The Advisory Committee on Laboratory Medicine should continue its fight against the exploitation of pathologists by hospitals and other corporations.

The pathologists of New Jersey appreciate the support of The Medical Society of New Jersey in their fight to make the Practice of Clinical Pathology a strong and ethical specialty of the Practice of Medicine.

MEDICAL CARE OF THE INDIGENT

George Blackburne, M.D., Chairman, Newark

There have been no new major developments in the system in vogue for several years in providing medical care to the indigent. It remains a responsibility of each municipality, to which state financial aid is available through the Division of Municipal Aid of the New Jersey Department of Economic Development.

During the past year the municipalities cooperating in the state program represented about 95 per cent of the state population, the only municipalities not cooperating being small municipalities with no appreciable indigent problem. Hoboken, the only large municipality not cooperating in the past, joined the program during the year.

Average contribution by the state to the municipalities is 40 per cent of the cost. Of the state's public assistance contribution, about 17 per cent went for "health". This included not only medical care, but also, drugs, hospitalization, home nursing and medical supplies. Physicians' fees recognized by the state are, in most cities, up to $1.50 per office visit, $2.50 per house call, and $4.00 for more distant visits. In Newark, however, the scale for house calls is $3 and $5 for day-time visits and night calls respectively. Last year, maximum state-recognized hospital cost was $5.00 a day. Recently this was raised to $7.50 a day.

The current public assistance (indigent load) shows an upward trend. The low load was in August 1945 with a case load of 4536 cases representing 7261 persons. In December 1947, the load had increased to 6774 cases representing 14,978 persons. The all time high was in March 1938 with 89,243 cases representing 283,618 persons, not including those on the W.P.A. rolls. Expenditures and cases included in the public assistance program do not include expenditures and cases covered in the categorical groups under New Jersey Department of Institutions and Agencies, or the Crippled Children Commission. There are 13,000 children on the active rolls of Crippled Children Commission, 24,000 persons entitled to benefits through the State Board of Child Welfare and 23,400 persons entitled to benefits as clients of the Division of Old Age Assistance.

It is the belief of this committee that adequate medical care is available to and attainable by the indigent population of the state. However, the Committee believes that the efficiency of a program for medical care of needy persons would be improved if (a) such a program were on a county rather than a municipal basis, (except in first and second class counties) and if (b) under such a program the medically indigent as distinct from the indigent, were more generally recognized under the provisions of the program.

It is recommended that Medical Service Administration of New Jersey, now operating the City of Newark Medical Plan, be consulted by any county society which believes that a project similar to the City of Newark Plan might be inaugurated within its county.

NURSING AND NURSING EDUCATION

H. Wesley Jack, M.D., Chairman, Camden

The Advisory Committee on Nursing and Nursing Education, (a committee of the Medical Practice Committee) has met on several occasions, and has also met with the New Jersey Board of Nursing.

We have participated in the formation of a *Manual* to be used in the training and the licensure of the practical nurses in New Jersey. We feel that the *Manual* is essentially good, and comparable with that used in other states. We appreciate the work that has been expended in its formation.

We also believe that the New Jersey Board of Nursing has fulfilled all the legal requirements of the law passed in June, 1947, concerning the licensure of the practical nurse. However, it is to be regretted that the licensing of the practical nurses does not seem to be much of a solution in providing the citizenry of New Jersey with better nursing care. If our constructive suggestions had been given more sympathetic and effective consideration by the Board of Nursing, better results in meeting the need for nursing care might be anticipated.

It was the hope of both the New Jersey Hospital Association and our committee, that certain sections in the *Manual* which we considered unwise, would be eliminated before publication. However, time has been very short and the *Manual* had to be in the hands of the publishers by the first of March, and distributed as soon as possible to the organizations wishing to have practical nursing schools.

The *Manual* can be revised in the future if it is found to have objectionable features. It is to be hoped that a too strict interpretation of the articles of the *Manual* will not be followed, but rather an attitude of liberality, so as to provide the hospital, physician, and the public with the needed nursing care which is so lacking at the present time.

PHARMACEUTICAL PROBLEMS

Chester I. Ulmer, M.D., Chairman, Gibbstown

Two meetings of the committee were held during the year. They were joint conferences with the Committee on Professional Relations of the New Jersey Pharmaceutical Association. We are continuing our efforts to create closer relationship between physicians and pharmacists for their reciprocal benefit and public welfare.

The fifth edition of the *New Jersey Formulary* made its appearance last year. Copies were sent to each member of our Society, and also to the pharmacists and hospital staffs in the state.

The *Formulary* contains many preparations which were developed at the New Jersey College of Pharmacy (Rutgers University). A number of new formulas were the result of research conducted under the New Jersey Formulary Research Foundation for which funds were made available jointly by the New Jersey Pharmaceutical Association and The Medical Society of New Jersey. Each contributed $500.00 last year and it is hoped that a similar grant can be repeated later.

We trust that the *New Jersey Formulary* will continue to receive wide acceptance and that the latest revision will take its place as a modest reference book of real value to the physicians of the state.

PHYSICAL MEDICINE

Bror S. Troedsson, M.D., Chairman, Orange

This committee held three meetings during the year, discussing general and specific programs and questions. The general program includes: (1) Encouraging the establishment of Departments of Physical Medicine in every hospital in the state. These departments should be under the direction of *physicians* trained in the field. Physical medicine is a recognized medical specialty which can be used in practically every branch of medicine. It is

not to the best interest of medicine to have these departments nominally in charge of an orthopedist, a roentgenologist, or a technician. (2) The Committee advocates that these departments be administered in accordance with suggestions contained in the Report of the Advisory Committee on Auxiliary Services, published in The Journal of The Medical Society of New Jersey, May, 1940. This plan is fair to the hospital, to the physician, and to the patient. It does not put the hospital in the practice of medicine. (3) The Committee is working on, and would like to see the Board of Medical Examiners adopt, some standards for the education and training of technicians in the field of physical medicine. At present there are none, and the public has no assurance that physical therapy treatments are given by persons with even a minimum training in the field. At present the situation is chaotic, and it should be corrected.

The lack of proper physical therapeutic facilities enables cults and quacks to flourish. Often it is an excuse for outside organizations to establish independent clinics, and ask for public support, diverting it from the hospitals and the physicians.

The committee solicits earnestly the active support of the Society and its individual members in this general program.

RADIOLOGY

W. James Marquis, M.D., Chairman, East Orange

Two years ago this committee reported that it would welcome any suggestions from the Medical Practice Committee in regard to ways of preventing exploitation of the radiologist by corporations with particular reference to the existing Blue Cross plan. It was then suggested that a study be made of existing contracts between radiologists and the hospitals. This has been done. Also it was suggested that advice of counsel be sought about the legal aspects of the corporate practice of medicine by the Blue Cross plan. This has been done and two members of the Medical Practice Committee met with a special committee of the Trustees to study this question. The Trustees heard our arguments and received the report of the counsel which indicated the present plan of selling the services of the radiologists was the practice of medicine by a corporation and was therefore illegal.

The committee of the Trustees recommended that this medical service be transferred from the Blus Cross plan to the Medical-Surgical Plan. As far as we have been able to learn no action has been taken on this recommendation by the Trustees.

We therefore recommend that during the next year every effort be made to correct this illegal practice of medicine by the Blue Cross plan. We suggest that the Medical Practice Committee study the actuarial soundness of the present Blue Cross contract in regard to the subscriber and also in regard to the hospital. It is the considered opinion of this committee that the present contract is, in some ways, ambiguous and may be differently interpreted by the subscriber and hospital management. It would be interesting to obtain opinion from counsel as to just what benefits are due the subscriber under the present contract.

Apparently there is little, if any, consultation held with organized medicine as to what medical services should or should not be included in the contract. As far as this committee has been able to learn, no representative of radiology has ever been consulted. We think that an unbiased actuarial study of the contract will reveal that the trustees of the Blue Cross plan have not allowed sufficient amount for the present costs of x-ray examinations. As a result, the hospital and the radiologist assume too great a burden in subsidizing the Blue Cross plan and are assuming an unwarranted and unjust obligation. And the private patient who is not a subscriber has to pay more than his share. We suggest that a committee be delegated to meet with a committee from the hospital association, the Blue Cross plan and the Commissioner of Insurance to study ways of correcting this illegal practice of medicine, to remove from the hospitals and the radiologists this unjust financial obligation which has been imposed on them by the present Blue Cross contracts and to form a simply worded contract which will not permit of ambiguous interpretation.

WORKMEN'S COMPENSATION

William K. Harryman, M.D., Chairman, Hackensack

During the past year nothing unusual developed to necessitate any special meetings of our Committee.

The matters referred to us have all been routine and adjusted without any special work.

We are just beginning to get copies of the new bills presented to the Legislature touching Workmen's Compensation. We will review them as they are presented.

Your Chairman has been attending the regular meetings of Mr. Harper's Advisory Committee on Workmen's Compensation together with Dr. Greifinger who is also a member of the Committee on Workmen's Compensation. We feel that while these meetings in many ways waste a lot of time, nevertheless we have been able to protect the medical profession in many small ways and look out for medical interests. I think that this particular association is a good one and I am sure Dr. Greifinger feels the same.

COOPERATING AGENCIES

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY
MEDICAL-SURGICAL PLAN OF NEW JERSEY

Norman M. Scott, M.D., Medical Director, Newark

This report is based upon the experience of the above named organizations during the calendar year of 1947. A supplementary report on Medical-Surgical Plan will be submitted at the time of the Annual Meeting of the Society covering the experience of the Plan up to March 31, 1948.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

Farm Security Medical Plan

This Plan was designed to assist low income farm families who were being rehabilitated by the Farm Security Administration of the Federal Department of Agriculture. It was inaugurated on May 1, 1941.

The Plan provided payment for physicians' services in the patients' homes and physicians' offices. It did not cover services rendered in hospitals excepting in obstetrical cases at time of delivery when the patient or patient's family could arrange for payment of hospital costs.

The highest number of participating families was 455 in March 1944. As the economic condition of this farm group improved, the number of participating families was reduced by December 1946 to 211 families, representing 904 persons. This resulted in an adverse cross-section of health in the group with a high sick rate which could not be supported by the subscriptions.

The situation was reported to the Trustees of the Society and with permission of the Board, the Plan was discontinued as current family contracts expired. The last of the family contracts expired November 1, 1947.

Medical Service Administration was reluctant to give up this plan. It filled the need of a worthy group. The income to the profession from this group was better than it otherwise would have been. It gave us the opportunity of experimenting with the problem of medical care distribution among low income rural families. It demonstrated the willingness of organized medicine to cooperate with a governmental agency when the need was demonstrated. The plan was successful just so long as the need was present and the demand produced a sufficient enrollment to result in maintenance of a sick rate which could be supported by the predetermined subscription costs. The experience demonstrates the fact that while we are apt to consider such problems as social problems, they must be for practical purposes considered purely as insurance problems.

We were not alone in our experience with this plan. Similar plans in other states were discontinued for the same reasons.

The total deficit, incurred during the last year, for payment of physicians' fees was $923.57 which was made up by transfer of this amount from the Corporate Account of the Administration.

Veterans Medical Care Plan

The contract between Medical Service Administration and Veterans Administration providing for a liaison officer to be employed by Medical Service Administration and to be stationed at the Regional Office of Veterans Administration was discontinued on December 31, 1947, and superseded by a new contract between The Medical Society of New Jersey and Veterans Administration effective January 1, 1948.

Edward Yorke, M.D., a member of this Society who occupied the position of Liaison Officer, rendered outstanding services to the veterans and physicians of this state and is deserving of the highest appreciation for his work.

The affairs involving Medical Service Administration and Veterans Administration have now been terminated excepting for an outstanding indebtedness amounting to $1891.88 which is reimbursable to Medical Service Administration.

City of Newark Medical Care Plan

This plan continues to be a successful demonstration of the cooperation of an official health agency with a voluntary agency controlled by the medical profession in providing medical care to the indigent and medically indigent.

It is a "reimbursement", not an insurance plan. It is operated under the provisions of an informal "agreement of understanding" providing for free choice of physician and payment for physicians' services on a fee for service basis. Medical Service Administration is reimbursed by the city for money expended for medical care plus 10 per cent toward payment of administrative costs. It is limited to payment for services rendered to the indigent and medically indigent confined to their homes because of illness. Fees payable are $3.00 per day visit and $5.00 per night visit.

The indigent are persons whose names appear on the welfare rolls of the City. The medically indigent are those persons residing in Newark, other than the indigent, who in the opinion of the Social Service Bureau of the City Board of Health are unable to provide themselves with adequate medical care because of low income.

The mean number of persons on the relief rolls of the City during 1947 was 2995 persons, as compared to 2100 persons in 1946. The approved claims for services rendered this group totalled $7823.00 or $2.61 per person per year, or .217 cents per person per month.

It is not possible to state the number of medically indigent persons in the city. For 1947, 2734 families were so classified and received treatment under the provisions of the plan. The total cost of the medical care rendered this group at the fees payable by the plan was $11,480.50.

As a result of our experience with this plan, there was evolved the "Principles of Cooperation between Organized Medicine and Health and Welfare Agencies". These "Principles" were approved by the House of Delegates of this Society in 1947 and later, with very slight modification, by the House of Delegates of the American Medical Association. These "Principles" aroused considerable interest throughout the country as a definite forward step in the solution of the indigent, medically-indigent problem.

Other Activities of Medical Service Administration

During the year the following problems were referred to Medical Service Administration.

The setting up of a state-wide plan for control of payment for services rendered clients of the Division of Old Age Assistance and Board of Child Welfare. These problems were studied and recommendations made to the Board of Trustees.

The problem of remunerating physicians for services rendered the clients of Crippled Children Commission. This problem was studied and recommendations submitted to the Board of Trustees. The solution of the problem awaits further consideration by the Crippled Children Committee of the Society.

Finances of Medical Service Administration

The assets of the Administration as of March 1, 1948, were as follows:

Corporate Account	$ 8,871.20
Revolving Account	13.58
Petty Cash	100.00
Due from Veterans Administration	1,891.88
Due from Medical-Surgical Plan	36.22
	$10,912.88

The estimated expense for the coming year is $3,612.50. The Administration will request no additional amount from the Society for administrative expense during the coming year.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

As of December 31, 1947, there were 143,700 persons enrolled in the Plan under effective contracts. This represents an increase of 55,612 persons during the year.

The number of groups enrolled as of December 31, 1947, totalled 806, an increase of 392 groups during the year. These groups are spread over the State.

The earned subscription income of the Plan and a summary of expenditures for the year 1947 were as follows:

Earned Subscriptions	$947,945.57	(100%)
Claims Incurred	681,922.85	(72%)
Operating Expenses	162,335.43	(17.1%)
Earned Reserve	103,687.29	(10.9%)

The rate of utilization of benefits under the contract was at the annual rate of 94 per 1000 persons enrolled as compared to a rate of 86 during 1946. This increased rate is due to (1) an increase in the utilization of the contract for emergency surgical services occasioned by accidental injury and rendered outside of a hospital within 24 hours after the accident, and (2) to increased rate of utilization for maternity benefits.

The total number of claims incurred during the year was 10,935 as compared to 5829 in 1946.

The types of cases were as follows:—surgical 63%, medical 20%, obstetrical 13%, and 4% involving both medical and surgical.

Adult females, mostly wives, continue to be the greatest recipients of the Plan benefits, their incidence of utilization of the contract being 132 per 1000 as compared to 67 for adult males and 77 for children.

Medical-Surgical Plan is a success in that it does provide the greatest medical need of under average income families, is self supporting and has accumulated satisfactory reserves. The cooperation of individual physicians has been excellent, and the number of complaints received in the office of the Plan is surprisingly small.

A more complete, supplementary report, as of March 31, 1948, will be submitted at the time of the Annual Meeting.

NEW JERSEY HEALTH CONGRESS

Stanley Nichols, M.D., President, Long Branch

The New Jersey Health Congress, which was initiated by the Public Relations Committee of The Medical Society of New Jersey following the recommendation of the American Medical Association to all state societies, has made steady progress during the past year toward its sole constitutional objective, namely, the "interchange of ideas and joint conference studies of the quality, quantity, availability, and distribution of health services rendered by the allied health professions with constructive recommendations to participating agencies, to the end that good quality health services shall be available to all people in New Jersey." Meetings of increasing interest and attendance were held in September, November, January and March.

ORGANIZATION

The Congress was organized in January, 1947, adopted a Constitution, and elected officers. The first year was largely taken up with the details of organization and discussions of the best methods of approach by the five allied health professions as to health service studies. For his untiring work during this crucial period, the Congress herewith tenders its thanks to its secretary, Mr. John J. Debus, who is also Executive Secretary of the New Jersey Pharmaceutical Association.

During this period, Dr. Harold Dodds, President of Princeton University, consented to serve as one of the Honorary Consultants of the Congress with the Honorable Alfred E. Driscoll, Governor of the state, and Dr. Robert C. Clothier, president of Rutgers University (who had both previously agreed to serve in that capacity). This acceptance was of vital importance to our organization because it is essential that for statewide study and recommendations of the Congress, the aid of the head of our state government and the heads of our two leading universities be secured.

With the approval of the officers, Board of Trustees, and Public Relations Committee of The Medical Society of New Jersey, Mr. James E. Bryan, Executive Officer of the Society, was elected Coordinating Secretary of the Congress in September, 1947, and has been of invaluable assistance in improving the or-

ganization, setting up programs, and furthering the progress of the Congress toward its constitutional objectives.

PROGRESSIVE STEPS

The first step toward attaining the purposes of the Congress was to request that each profession make a study of the quality, quantity, availability, and distribution of health services rendered by that profession. These studies are now under way and provisional reports were rendered in November 1947. As these studies are completed by each profession, they will be discussed by the entire Congress and recommendations made to participating agencies in order to secure their active statewide support where needed to aid each profession.

The following resolution, adopted by the Board of Trustees of The Medical Society of New Jersey in November, 1947, was presented at the January meeting of the Congress for discussion, by Dr. Royal A. Schaaf, President of the Society:

Whereas, the health and welfare of the people of New Jersey require the expansion of facilities for the undergraduate training of nurses, and for the payment of hospital cost for hospital care of persons in the low income group, and for an expanded program for the care and treatment of wards of the state,

Be it resolved, that The Medical Society of New Jersey invites the attention of the Governor and Legislature to the need of additional state revenue for the following specific purposes:

1. To subsidize nurses training schools throughout the state of New Jersey under the general direction of Rutgers University.
2. To assist local communities in defraying the cost of hospital care for indigent and medically indigent persons in voluntary hospitals.
3. For an expanded program for the care and treatment of wards of the state, the care and treatment of whom is the responsibility of the State Department of Institutions and Agencies.

The Congress adopted the following resolution:

Resolved (1) that the New Jersey Health Congress urge its members to support the principals of the resolution submitted to the Congress by The Medical Society of New Jersey.

(2) that the Congress authorize its president to appoint a committee on emergency governmental aid for hospitals.

(3) that this committee be commissioned by the Congress to collaborate with appropriate agencies in drafting specific plans for action to meet the present financial crisis of the voluntary and state hospitals, and other institutions affected, and that this committee be granted the full authority of the New Jersey Health Congress to recommend the support of those proposals to the member agencies of the Congress.

The president then appointed Mr. George Buck as chairman of this special committee. The March meeting of the Congress will be devoted to discussions of three top priority problems: (1) cash sickness benefits legislation (2) the problem of full-time local health units, and (3) government aid to hospitals.

STATE BOARD OF MEDICAL EXAMINERS

E. S. Hallinger, M.D., Secretary, Trenton

During the period of January to December, 1947, the Board examined one hundred and four applicants for a license to practice medicine and surgery. Eleven of the applicants were graduates of osteopathic colleges. Of these, 81 per cent [1] passed the examination.

The Board also examined seven applicants for a license to practice chiropody.

All candidates in both examinations were citizens of the United States.

Two hundred and eighty-nine licenses were issued to applicants for endorsement of a license from another state, or to doctors holding a diploma from the National Board of Medical Examiners, who presented credentials which met the requirements for examination in New Jersey. See Table II, next page.

Credentials covering medical and hospital work were verified by questionnaires sent to the colleges and hospitals in this country before a license was issued.

The laws governing the practice of medicine, surgery, osteopathy and chiropractic, do not provide for an annual registration. The Board does not, therefore, know whether the number of licentiates in the state is increasing or decreasing.

1. See Table I, next page.

TABLE I—CANDIDATES EXAMINED

	Passed	Failed	Ratio Passed
MEDICAL			
UNITED STATES			
84 Graduates of Medical Schools	77	7	91%
11 Graduates of Osteopathic Schools	9	2	81%
7 Italy	5	2	71%
1 France	1	0	100%
1 Austria	1	0	100%
CHIROPODY			
7 United States	7	0	100%
	100	11	90%

TABLE II—RECIPROCITY LICENSES

Country of Graduation	Total
United States	260
Canada	5
Great Britain	6
Austria	4
Germany	2
Italy	4
Hungary	1
Switzerland	3
Ireland	1
The Netherlands	1
Poland	2
	289

TABLE III—LICENTIATES LOST TO THE STATE

Physicians—Endorsed to other states	90
Osteopaths—Endorsed to other states	2
Medical—Licenses revoked	2
Medical—Licenses suspended	1
Medical—Complaint dismissed	1
Medical—Revocation or suspension pending	1
Medical—Petition for reinstatement postponed indefinitely	1
Chiropody—Licenses revoked	1
Physicians—Deceased	83
Osteopaths—Deceased	3
	185

Annual registration would give the Board accurate information relative to the number of physicians practicing in New Jersey and would enable physicians to assist the Board in enforcing the law by reporting unlicensed practitioners in their vicinity.

The laws governing the practice of chiropody and midwifery do provide for an annual registration and our records show a decrease of sixteen in the number of chiropodists registered on November 1st, 1947, and a decrease of sixteen midwives for the same period.

TABLE IV—COURT ACTIONS

Convicted, pleaded guilty or settled	31
Pending in the courts	19
Decision reserved	3
Lost by board	2
Won by board	1
	56

TABLE V—HEARINGS BEFORE BOARD

Medical—Licenses revoked	2
Medical—Licenses suspended	1
Medical—Complaint dismissed	1
Medical—Revocation pending	1
Medical—Petition for reinstatement postponed indefinitely	1
Chiropody—Licenses revoked	1
	7

TABLE VI
INVESTIGATIONS AND INSPECTIONS

Druggists practicing medicine	11
Prescribing herbs and drugs	15
Unlicensed medical doctors	13
Licensed medical doctors failing to display name	4
Unlicensed chiropractors	43
Licensed chiropractors exceeding license	4
Licensed chiropractors assisting an unlicensed person	1
Licensed osteopaths failing to display name	1
Unlicensed chiropodists	1
Licensed chiropodists practicing after failure to register	2
Licensed midwives practicing after failure to register	1
Naturopaths	11
Physio-therapists	22
Laying-on-of-hands	1
Medical—Revocation	3
Medical—Suspension	1
Chiropody—Revocation	1
Electro-therapists	2
Massage	1
Unlicensed medical school	1
"Psychoanalysts"	4
Diathermy treatments	3
Scalp treatments	2
Miscellaneous	8
Total investigations and inspections	156
Total visits made and treatments received in making the investigations and inspections	1,046
Average number of visits per investigation	6.7

COUNTY SOCIETIES

ATLANTIC

CLARENCE B. WHIMS, M.D., President, Ventnor

The list of invited guest speakers at the Atlantic County Medical Society meetings, together with their topics is as follows:

September—(1) Dr. Joseph C. Bell of Louisville, Ky., "X-ray Examination in Malignant Lesions of the Bowel".

(2) Dr. Gilbert Heubelein of Hartford, Conn., "Diffuse Metastatic Pulmonary Lesions".

October—Dr. Lawrence I. Kaplan, Philadelphia, "Neurology and the General Practitioner".

November—(1) Dr. William H. Kammerer, New York, "The Treatment of Arthritis".

(2) Dr. Robert S. Garber, Trenton, "Court Commitments and Facilities of the N. J. State Hospital".

December—Dr. Charles W. Dunn, Philadelphia, "The General Practitioner's Endocrine Therapeutic Problems".

January—Dr. Earl D. Bond, Philadelphia; Dr. Frank E. Wilson, Haverford, and Miss Dorothy Hankins, Philadelphia, "Problems of Family Life".

February—Dr. H. L. Bockus, Philadelphia, "Diagnosis and Treatment of Pancreatic Disease".

March—Dr. Allen Pepple, Richmond, Va., "Contact Dermatitis".

Eight new regular members were elected into the Society: They are Doctors Werner Hamburger, Abraham Paul, Robert Sinderbrand, Arthur Dintenfass, Joseph L. McGahn, Ellis H. Allar, Robison D. Harley and Charles H. Baldwin.

Five new associate members were elected into the Society. They are Dr. David F. Bew, Dr. F. A. Erskine, Dr. Herbert D. Axilrod, Dr. F. Sterling Brown and Dr. Victor M. Ruby.

Two members were transferred in from other societies and two members were transferred out. One died, and one resigned.

The views of this Society on the various medical bills and toward organized medicine were discussed with Congressman Hand and with the Cumberland and Cape May County Societies.

A survey of uterine cancer, limited to the Papanicolaou smear method was begun early in 1948, with two diagnostic clinics, one in Hammonton, the other at Somers Point. The work is limited to study of cases for the purpose of diagnosis. The clinics are to continue in operation for about one year. A chest x-ray survey was conducted in October, 1947, and will be repeated in February, 1948.

Establishment of a mental hygiene clinic at the Atlantic City Hospital has been recommended.

A memorial meeting, honoring the memory of the late Dr. Clyde M. Fish was held in November at the Pine Rest Sanatorium.

Another post-graduate course began in February and will continue each Tuesday for six weeks.

1. February 10—"Treatment and Diagnosis of Prepsychotic States". Dr. Joseph Hughes, Professor of Psychiatry, Women's Medical College of Philadelphia.
2. February 17—"Evaluation of Functional and Organic Hyperkinetic States". Dr. A. M. Ornsteen, Assistant Professor of Neurology, University of Pennsylvania.
3. February 24—"Problems in Diagnosis and Treatment in Pulmonary Diseases". Dr. Leon H. Collins, Jr., Associate in Medicine, University of Pennsylvania.
4. March 2—"Physiology of the Thyroid Gland. Action of Anti-Thyroid Drugs". Dr. Maurice Breuger, Chief of the Division of Pathologic Chemistry, New York Post-Graduate School and Hospital.
5. March 9—"Cardiac Considerations in General Practice". Dr. Samuel Bellet, Assistant Chief, Division Cardiology, Philadelphia General Hospital.
6. March 16—"Present Status of Chest Surgery in Pulmonary Disease". Dr. W. Emory Burnett, Professor of Surgery, Temple University.

During the year, a varied program was arranged through the local broadcasting station. Talks were given over the air by physicians and consisted of medical topics of general interest to the public.

BERGEN

Rudolph C. Schretzmann, M.D., President, West Englewood

The Bergen County Medical Society has had a busy year. Our program of scientific sessions represented a compact refresher course for members, covering almost every specialty in medicine. The topics were as follows:

September—Use and Misuse of Hormones.
October—Psychosomatic Problems.
November—Hypertension.
December—Cancer.
January—Antibiotics.
February—Diabetes Mellitus.
March—Constitutional Diseases with Oral Manifestations.

During the year, thirteen new members were elected, four died, nine transferred out to other societies, while four were received by transfer to the Bergen County Medical Society. The Annual Banquet was held in November and was featured by the presence of three past-presidents of The Medical Society of New Jersey—Doctors Snedecor, Quigley and Alexander.

A special graduate educational program was set up at the Hackensack Hospital. The subjects were varied, of general interest, and offered those in attendance a valuable kaleidoscope of modern medicine. Topics covered included: (1) Electrocardiography (2) Marriage Problems (3) Multiple Sclerosis (4) Gastroenterology in General Practice (5) Violent and Suspicious Deaths (6) Physical Medicine for the General Practitioner (7) Geriatrics and (8) Office Gynecology. The faculty was carefully chosen and represented an all-star galaxy of medical authorities.

A problem of special interest to us this year was that of hospital needs for Bergen County. The committee's report, which was adopted by the Society, is presented, in abstract, below:

The obvious inadequacy of the present situation is illustrated by the low-ratio of 1.61 beds per 1000 population in this county, contrasting with 4.48 beds in Essex and 4.47 beds in Passaic. Authorities recommend a ratio of 4.5 beds. We have the most critical shortage of any county in the state.

A study of the current needs in the county made by inquiry among the doctors, hospital people, and social workers, reveals the most acute shortages in the following categories:

1. Semi-private beds for the low-income patients in the general hospitals. Each hospital has a waiting list. It has taken as long as five weeks to gain admission for a non-emergent patient. A steady increase in the number of semi-private patients has taken place.

2. Beds for chronically ill patients are desperately needed by all of the agencies who have the problem of placing and caring for these people.

3. Additional beds for psychiatric cases are required to supplement the present small ward in the county Home.

4. Additional beds for ward service. The development of this county makes this a serious need. The present plans for the enlargement of the County Hospital at Bergen Pines comprise an addition to the existing Administration Building of 440 beds. Of these 190 will be for tuberculosis patients, 34 for psychiatric cases, and the remaining 200 beds for the chronic ill who require hospital care, and for such other cases as the law prescribes. One building will be remodeled as an infirmary for the chronically ill. When this plan is completed, in about three years, 600 beds will be available for hospital use for which an attending medical and surgical staff will be appointed. There will be no private or semi-private beds and admission will be through voluntary hospital transfers or by request of physicians. The cost is approximately $3,000,000 for the new hospital.

To answer these hospital needs of the County the Committee recommends:

1. That additional semi-private beds be provided by voluntary hospitals.
2. That the governing body of the county continue its liberal financial support of the general hospitals. This remains as the keystone for their expansion.
3. That the Bergen County Medical Society endorse the plan for modernizing and enlarging Bergen Pines as presently announced by the Board of Freeholders.
4. That a copy of these resolutions be sent to the governing boards of each hospital and to the Board of Freeholders.

WOMAN'S AUXILIARY

On March 10th, 1948, the State Medical Society officers and Dr. Rudolph C. Schretzmann, president of the Bergen County Medical Society, were hosts at a luncheon at the Hackensack Golf Club, attended by the doctors' wives and eligible ladies of their families for the purpose of reorganizing the Woman's Auxiliary for the Bergen County Medical Society.

BURLINGTON

E. Warren Rodman, M.D., President, Beverly

The Burlington County Medical Society reports a year of satisfactory progress. Probably our outstanding achievement has been in the field of public relations. Our Public Relations Committee, in conjunction with the Burlington County Chapter of the American Cancer Society, sponsored three meetings for the general public, of an educational nature, on the subject of "Cancer". The first was held in January. Dr. Paul R. Sparks spoke on "The Role of the General Practitioner and Cancer Control", and Dr. William E. Bray explained the activities of the Cancer Society. The second meeting was held in February. Dr. John T. Bauer spoke on "Pathology and Research on Cancer" and Dr. Thomas J. Summey on "Surgery and Cancer". The attendance at both of these meetings was large, the reaction of the public was one of intense interest, the speakers presented their subject matter in clear-cut, understandable form, and many favorable comments have been received. The third session was held March 11, 1948, the regular meeting night of the Burlington County Medical Society. Previous to the business meeting there was a discussion on cancer to which the public was invited. Dr. Snegireff of the Cancer Society was moderator and the panel included Drs. Shipps, Hornberger, Borzell, Viteri and Rodman.

The attendance at our regular meetings has been fairly good, but there is room for improvement, and we are endeavoring to improve it. The programs have been excellent, and speakers have been selected with the aim of presenting subjects of interest to the general practitioner.

Through the efforts of our secretary, the records of our Society from the time of its founding up to the present time have recently been stored in a vault for safe keeping at very small cost to the Society.

A year ago our constitution and by-laws were completely revised, and estimates are now being obtained to have them printed in booklet form so that each member may have a copy for reference, and that each new member may receive a copy upon being received into membership.

It is with deep sorrow that we report the death of Dr. Gerald E. McDonnel who was to have been our president this year. We have gained two members, by transfer from other societies.

Too much credit cannot be given to the work of our officers and committees. All that has been accomplished has been a result of their diligence and whole hearted cooperation.

CAMDEN

James S. Shipman, M.D., President, Camden

The Camden County Medical Society installed its officers for the year 1947-48 at the May 1947 session. At that meeting, the retiring president, Dr. Henry B. Decker, delivered a splendid address on "Medical Education". He particularly emphasized post-graduate training of the general practitioner.

In accepting the office of president, I reminded the Society that we were past our one hundredth birthday and that we should devote more energy toward the present and the future rather than the past. The inadequacy and the unattractiveness of our present building where we meet also were pointed out. Efforts were made to stimuate enthusiasm for a new and more modern building. A committee of seven members, headed by Dr. R. S. Gamon was appointed to study the problem of remodeling our old building or acquiring another.

The annual outing was held on June 19, at the Riverton Country Club. This was an entirely social occasion to which we invited members of the neighboring county medical societies. As the result of careful planning and able direction by the chairman, Dr. George P. Meyer, the outing was well attended and enjoyed.

The program for our October meeting was an innovation in that we had no scientific papers. It was felt that the Society at large ought to know more about the happenings in the State Society, and the A.M.A., as well as the activities of our own committees. This

entire meeting, therefore, was devoted to reports from committee chairmen.

This program proved to be interesting and informative. We recommend it to more county societies. The Building Improvement Committee recommended that we sell our present structure for a fair price and plan for a new and more modern building elsewhere. This was approved unanimously by the Society. The Board of Trustees was instructed to try to negotiate a sale. So far this has not been consummated.

Our November meeting was devoted to "Psychiatry". Dr. Robert S. Garber of the Trenton State Hospital and Dr. John E. Davis, Chief of the Veterans Administration's Mental Hygiene Clinic in Philadelphia, discussed interestingly and informatively the types of commitments to New Jersey state hospitals, as well as psychiatric rehabilitation of the veteran. Mr. James E. Bryan, the new Executive Officer of the State Society was introduced to our members. With his pertinent remarks and friendly manner, he made a highly favorable impression.

The County Society was requested to endorse the local Community Chest campaign and to assist in the stimulation of a more generous contribution to this fund by our members. Dr. Walter A. Crist was appointed as chairman of a committee to solicit funds for this worthy cause from all the doctors of the county.

I am happy to say that all of these committees did a fine piece of work. Contributions from the doctors of Camden County for this year were substantially increased over those of previous years.

Dr. Charles C. Wolferth of the University of Pennsylvania, our guest-speaker at the December meeting discussed recent advances in the treatment of cardiovascular diseases. It was a privilege to hear this timely subject so ably presented.

The January meeting, as usual, was "Case Reports by Members of the Society". That meeting, which always has been well attended, was enjoyed by all the members. This was evidenced by the number of free discussions. Our president-elect, Dr. George B. German presided, our Society's president being in Havana to attend the Pan-American Congress of Ophthalmology.

The February meeting was devoted to dermatology. Dr. Donald Pillsbury, Professor of Dermatology at the University of Pennsylvania, discussed "Bacterial and Fungous Infections of the Skin and their Treatment in General Practice". He showed many beautiful slides to illustrate his cases.

Dr. Edwin R. Ristine, chairman of our Public Relations Committee, recommended that the County Society employ an executive secretary, capable of handling the increased clerical and other business of the society, and of acting as a director of public relations. The Society accepted this recommendation and the services of Mr. Allan R. Eckman, a public relations counsel for a number of non-profit organizations in Camden, with experience that fits him for the highly ethical conduct of this office, have been secured. This arrangement will mean much to the Society. In these times, when attempts are being made by many politicians to place the medical profession in an unfavorable light, we ought to make every effort to give organized medicine an effective and accurate presentation of its objective and constructive thinking.

Because of a proposal to sell our County institutions at Lakeland to the State of New Jersey, it was felt that action should be taken by our Society. Our executive committee met and, after discussing the proposed sale, instructed me to appoint a committee to study and make recommendations regarding medical facilities in the county. The committee, headed by Dr. Thomas K. Lewis has already had two meetings with the Board of Freeholders. It has made a tour of inspection of the entire plant at Lakeland. Dr. Lewis and his associates have recommended that a specialist in hospital management be engaged to make a complete survey of the entire physical and professional equipment at Lakeland and submit recommendations how the institution can best serve the county needs. Having done this, he should recommend further how, with a view to the best utilization of available buildings, equipment, facilities and personnel, we can make adjustments to improve the care of the chronically ill and insane people of our county.

"Hospital Night" featured the March meeting which was held at the West Jersey Hospital. This event has been very popular with our Society for many years. On alternate years the West Jersey Hospital and the Cooper Hospital act as hosts. The regular business of the Society is transacted as usual after which, several interesting cases are presented and discussed by members of the staff of the host hospital.

At our April meeting, there was a presentation of the Blood Bank subject by W. T. Read, for the Red Cross.

During the year, we have cooperated with

Mrs. A. G. Pratt, the president of our Woman's Auxiliary. We have derived a great deal of inspiration and help from that group. The women have been most effective in their program to stimulate interest in the profession of nursing. They had a fine meeting for all the women's clubs of Camden county. At that time exhibits and talks were given. The Auxiliary has held numerous card parties, the proceeds of which have been used to establish a scholarship for nursing in the two Camden hospitals.

Recently a helpful and auspicious meeting emphasizing "The Hygiene of the School Child," was held at the office of the County Superintendent of Schools. It was organized and presided over by Mrs. Karl S. Russell on behalf of the Woman's Auxiliary of the Camden County Medical Society. School physicians, nurses, and dentists were present. Mr. Bryan was present to represent the State Society. Speakers stressed the need for a closer relationship betwen county Boards of Education and the County Medical Society and its Auxiliary. It was pointed out that the school physician ought to function more as a coordinator than an examiner. Speakers indicated that the school physician should strive to gain the cooperation of the family doctor and wherever possible have each school child examined annually by the family doctor and to bring a report of that examination back to school authorities. This procedure, it was held, will strengthen the program to discourage mass examinations.

The County Medical Society was represented at this meeting by its president. We emphasized strongly a closer relationship of family doctor and patient. The outline, as given by the State Society, is somewhat ambiguous on this subject. I trust that soon it will be cleared up. We are in full accord with this program and have requested that Mrs. Russell be allowed to meet with the County Board of Education and to try to get its full cooperation.

I want to express my sincere appreciation to all the officers and committees of the Society for their splendid cooperation throughout the year. Without that fine support, it would have been impossible for me to serve as president. I especially wish to thank our most efficient and loyal secretary, Dr. A. G. Pratt, also Doctors H. B. Decker, T. K. Lewis, R. S. Gamon, H. Wesley Jack, and all past-presidents for their advice and help. Dr. William T. Read, chairman of the program committee, supplied us with excellent programs. I wish to thank him again. I would like to mention the names of many more but time and space will not permit.

The membership has expanded since October 1947, from 235 to 247. That growth is a credit to our chairman of the Membership Committee, Dr. H. D. Barnshaw. We are making every effort to have all eligible physicians in the county become members of the Society. Average attendance for the year has been 60, with 95 attending special meetings. This is far too low and should be made better.

The Society is well satisfied with the National Casualty Insurance Company and the service as rendered by them through their representatives, E. and W. Blanksteen. We are encouraging every member to carry this insurance and to take advantage of the new, increased coverage which is now being offered.

I extend profound thanks to the members of the County Society for the honor and privilege of serving them as president for the past year. I have thoroughly enjoyed it.

CAPE MAY

J. S. D. Eisenhower, M.D., President, Wildwood

In the report of the previous period, emphasis was laid upon plans for a hospital to serve the physicians of the county. Arrangements for this hospital continue to mature so that the time of building apparently approaches. Although this hospital plan is a lay project, and rightfully so, the members of The Medical Society of Cape May County have been indispensable from a moral standpoint, from the standpoint of technical advice, and from a pecuniary vantage.

Concomitant with the fetal growth of the hospital has begun another potent medico-social device, namely The Woman's Auxiliary to The Medical Society of Cape May County. Mrs. Mancusi-Ungaro has given liberally of her time and ability to the inauguration of the organization, as have the other fine members of her staff. The Auxiliary has, of course, been formed with the full approval of the medical men.

Meetings during the past year have been

marked by a visit from the President-Elect, Dr. J. Howard Hornberger, Mr. James E. Bryan, Executive Officer of The Medical Society of New Jersey, and a discussion on medical jurisprudence.

As president of The Medical Society of Cape May County, it is fit and right that I give credit to Drs. Crowe, Brooks, and Way who, by advice and help, have done much to enervate our organization. By using these names it must not be inferred that they were alone, for it has been only by the full cooperation of all the members that our (and any) society can functionally exist.

CUMBERLAND

Sidney L. Siegel, M.D., President, Millville

During the past year there has been considerable improvement in the attendance at our meetings. Our roster has been increased by the following new members: Drs. Sherman Garrison, Jr., Jessie W. Carll, Ralph S. Phillips, Arthur D. Sewall, Bridgeton; Dr. Harold W. Hendrickson, Cedarville; and Drs. Walter L. Sydoriak, and Robert C. Brown, of Millville. Our Society mourns its loss through the death of one of our oldest and most active members, Dr. H. Garrett Miller of Millville.

We were honored by visits from Dr. J. Howard Hornberger, president-elect, and Mr. James Bryan, Executive Officer of The Medical Society of New Jersey, as well as from Dr. Chester I. Ulmer, the Councilor of our District.

Our Society approved the mobile Eye Clinic and jointly sponsored with The Medical Society of New Jersey a series of health broadcasts presented as a special service by one of the local stations.

We succeeded in having one of our members elected Coroner and hope that future holders of this office will also be members of this Society.

The Cancer Committee headed by Dr. Anthony Pino has been extremely active and has done splendid work. It has cooperated with the National and State Cancer Societies and is in the process of establishing cancer clinics in those hospitals in the county which have not had them.

The scientific programs, under the auspices of our vice-president, Dr. Charles Cunningham, chairman of the Program Committee were as follows: Harry S. Shay, M.D., who spoke on "Liver Diseases"; Henry A. Cotton, Jr., M.D., who spoke on "Mental Hygiene and Psychiatry"; Henry Royster, M.D., who spoke on "Thrombo-Embolism"; and J. Gershon Cohen, M.D., who spoke on "The Atom: Hail or Hell". As is the custom, dinner was served after each of our meetings.

ESSEX

Harrold A. Murray, M.D., President, Newark

The Essex County Medical Society has had an active year. This has been due to the cooperation of its members and the untiring work of the various committee chairmen. For the most part a group of younger men, veterans when possible, were selected to head all the active committees.

The initial session was a well attended dinner meeting of the society with Dr. Morris Fishbein as the speaker. The newly formed male chorus made their first appearance at this meeting. This group consists of members from various hospitals, about twenty-four in number, and has served to promote a spirit of good fellowship. They have sung at various functions throughout the year with outstanding success.

Health Week was observed early in October. It consisted of exhibits, moving pictures and lectures each afternoon and evening during the week at the Academy of Medicine, to which the public and school children came in large numbers. Various diagnostic tests were performed on visitors under the direction of the several committee chairmen. Daily radio broadcasts and newspaper articles on health subjects were prepared for the week.

We have continued our objectives in educating the public by sending the exhibits to schools when requested, and by a series of

twenty-three weekly broadcasts on Station WNJR. Several broadcasts on health subjects have been given on Station WAAT during the year.

Four meetings of the newly formed Welfare Committee were held at quarter-year intervals. The entire membership was invited to these. Everyone was encouraged to voice his opinion on the activities of the society. They have been most interesting and helpful, and in many cases very constructive.

The graduate courses at Seton Hall College under the sponsorship of the Society have been well received. Fall and spring sessions were held with capacity attendance at all classes.

During the year, the Civilian Blood Bank was formally started. This is sponsored by the society with the Board of Freeholders financing its operation, and the Red Cross helping to secure donors. Since October, over 2500 pints of blood have been collected and distributed to residents of the county.

A Chronic Disease Registry has been formed and is the first approach to the solution of our greatest unmet need. "Rooming out care" by physicians, nurses and housekeepers will help relieve this desperate situation and unburden the tax on our hospitals.

The Human Milk Bank sponsored by the society has enjoyed its most successful year. With a large reserve supply of breast milk we have been able to distribute milk throughout the state, to New York and Philadelphia in emergencies.

Through the efforts of the Council and the Hospital Relationships Committee the ruling for retirement from active service in our hospitals at the age of 65 is being enforced in about sixteen hospitals in our county. The remaining nine hospitals are considering the ruling and will probably enforce it within the next few months. This has met with the hearty approval of the younger men on hospital services.

The Medico-Legal Testimony Committee is preparing a booklet, *The Doctor—A Witness* which will be released within the next few days. This will serve as a guide to the younger man unfamiliar with proceedings in court.

The Child Welfare Committee has published a pamphlet *Immunization Procedures* bringing the members of the society up to date on newer advances in protective immunity.

The School Health Committee has cooperated with the Woman's Auxiliary in establishing the School Health Council which will put into effect the Four Point Program on School Health proposed by The Medical Society of New Jersey. The Council is a reality and has had several meetings.

The Newark Plan for the Care of the Indigent still continues on its successful journey, and the society has cooperated with the State Board of Child Welfare in furnishing physicians of their own choice for their dependent ones, at the prevailing fee schedule.

The officers of the society and the Legislative Committee entertained members of the Assembly from our county at dinner. Various bills now being presented to them were thoroughly discussed. This was to our reciprocal advantage.

With the desire to acquaint our large membership with our many projects, we conducted our regular stated meetings at various hospitals throughout the county. This enabled members from a distance to attend the meetings and hear outstanding speakers on important medical subjects. It was a new venture and was well received.

The many advisory subcommittees to the Public Health, Medical Practice and Public Relations Committees have been instrumental in promoting a feeling of friendship and good will among our various non-medical groups which probably has been the outstanding accomplishment of this administration.

GLOUCESTER

Joseph F. Hughes, M.D., President, Woodbury

During this year our regular meetings have been well attended. Our speakers have included Doctors J. H. Hornberger, and Royal A. Schaaf, President-Elect and President of The Medical Society of New Jersey. Doctors A. E. Rakoff, R. Kline, Lowell Erf, and C. C. Wolferth spoke at our scientific sessions.

New members include Doctors James Dickensheet, A. J. Battaglia, W. D. Bundens, Norman K. Chesley and John Miller Wilcox.

Our annual social session was a success, being attended by over a hundred people.

In December we lost a distinguished member, Dr. Henry B. Diverty. He passed away

in his 83rd year, after a prolonged illness. The record of his service to the community and to the profession has been outstanding. He had served as president of the County Society and was president of the Board of Medical Examiners. His genial presence is greatly missed by our society.

We are now sponsoring the four point child health program, approved by The Medical Society of New Jersey. The first council meeting, including members of the local Boards of Education, has been held so that study on the program could be launched.

Mr. James E. Bryan, Executive Officer of the State Society, came to Gloucester County twice and received a cordial welcome by our members. He has kept us up to date on the present activities and the future programs of the State Society.

The cooperation of the committees and the members has been gratifying. As long as our County Society stays united, and interested in free medical practice we will have a strong force in counteracting the Utopian schemes of socialized medicine.

HUDSON

Raymond S. Driscoll, M.D., President, Bayonne

Now in the fourth quarter of the 1947-48 Official Year, the component society of Hudson continues its active support of the programs formulated by the American Medical Association and its cooperation with The Medical Society of New Jersey in the various aspects of its medical endeavor.

Attendance at meetings during the current season has shown marked improvement over the war years, but further improvement is constantly urged. The names of outstanding authorities in their respective fields have made our scientific programs attractive to a large number. Among them have been Drs. R. Franklin Carter, J. Wilfrid Forster, J. Russell Twiss, C. G. DeGutierrez-Mahoney, Louis F. Bishop, Jr., Raphael Kurzrok and Elmer L. Sevringhaus. In addition, one of our own members, Dr. A. E. Jaffin, arranged a symposium on tuberculosis in which Dr. Edgar M. Medlar participated. At the April meeting we presented Dr. George T. Pack and his associates—including Drs. John S. La-Due, Paul Murison, Juan Jimenez, William Trevor, Isabel Scharnagel and Robert Booher. At the final meeting of the season on May 4th, Dr. Otto Steinbrocker has consented to be the guest speaker.

Active membership has shown a healthy increase during the past year, many of the recent electees having served in the armed forces. The Society suffered the loss of seven members by death, among them Dr. Thomas McG. Brennock who for many years was prominent in the activities of both state and the county medical societies; Dr. David I. Nalitt who passed away suddenly while filling the office of president-elect; Dr. Alexander L. Smith, an honorary member; and Dr. Harry J. Kelly, Dr. Seth B. Sprague and Dr. Arthur J. Walscheid. Honorary membership was conferred during the year upon Dr. Samuel Selinger of West New York and Dr. David R. Atwell of Hoboken.

Operation of the Hudson Plan for Veterans Medical Care was suspended during the early part of the year, with payment of all physicians and hospital centers that participated in the work.

Among important committee projects, the blood program in Hudson County is the one upon which the Public Health Committee has been focusing special attention. The complicated nature of a peacetime program such as the Red Cross proposes demands consideration of members of this committee in joint session with executive and medical administrators of Red Cross. The Society gave its approval to the establishment of a standardized blood donor index system and also endorsed the proposed blood program in the North Hudson area under the chairmanship of Dr. Frank A. Marshall. It withheld approval, however, of establishing similar programs throughout the county, pending more detailed study.

Also in the spotlight this season is the Cancer Committee of which Dr. J. B. Faison is chairman. While important problems still confront this group, some of the major obstacles in the current cancer program have been removed. Future developments within the program will be predicated upon sound medical principles and practice. Acutely aware of the responsibility of the medical profession, the Cancer Committee of the Society stands willing and eager to guide the local chapter of the American Cancer Society toward fulfillment of the worthy purpose for which it was organized.

In March, the Society assumed formal sponsorship of the Jersey City Health Council,—the result of a previous exchange of ideas between Mr. Harry F. Downes, president of the local health council, his associates and representatives of the medical profession. The object of the sponsorship is to bring together medical, allied professional and citizen groups for interchange of opinion; and to encourage, stimulate, foster and support the establishment of health and medical care programs in the local area, in accordance with the current health program of the American Medical Association.

The Society takes pride once more in the accomplishments of its Committee for Postgraduate Medical Education. Under the leadership of Dr. George Ginsberg and in cooperation with The Medical Society of New Jersey, a spring course has been arranged—beginning on April 2 and ending on May 7, 1948. The faculty includes: Drs. Irving S. Wright, Edward Weiss, George M. Lewis, John H. Garlock, Byron Stookey and Leslie O. Ashton.

It is felt that a word concerning our monthly publication should be incorporated in this report, since it is our spokeman. Despite the steady rise in printing costs that is intimidating less intrepid organs, our little *Bulletin* goes blithely forward in its own self-sustaining way, reflecting, we think, our dignified spirit.

We wish to make mention, also, of our one Society-sponsored social event of the season, the second postwar annual dinner held on April 17, 1948, at the Hotel Astor in New York City. This was worthy of the best traditions of the Society. Besides the enjoyment of merely being together with conviviality the keynote, there was a speaker of national reputation and something unusual in entertainment as well, which complemented the best efforts of the Hotel Astor cuisine.

Lastly, in the recording of our anticipated participation in the 182nd Annual Meeting of The Medical Society of New Jersey, to which we look forward with pleasure, another page in the history of venerable Hudson becomes inscribed for posterity.

HUNTERDON

Raymond J. Germain, M.D., President, Clinton

Hunterdon County holds the unique position of being the only county in the state without a general hospital.

Early in 1947, the Hunterdon County Agricultural Board, a very active and progressive organization, appointed a committee to study the hospital situation in Hunterdon and neighboring counties. A a result of this preliminary investigation, they decided to continue with further study. E. H. L. Corwin, Ph.D., Executive Secretary of the New York Academy of Medicine and Health and Hospital Consultant, consented to make this survey. Dr. Corwin met with the Medical Society during his study, and it was generally agreed that Hunterdon County is in need of a hospital and health center.

Of especial interest is the fact that the proposed Hunterdon County Hospital may be associated with one of our foremost medical schools.

The Society, which is working very closely with the Hunterdon County Agricultural Board, is not only unanimously in favor of the project because of the obvious reasons, but also because it will increase its activities. Because of the lack of a hospital, many of our committees are unable to function. The addition of a health center with a county health officer would also furnish the nucleus for a county-wide public health program; coordinate child welfare activity, maternity, cancer control and cardiac clinics and so forth.

Our Cancer Committee has been active in cooperation with the Hunterdon County Chapter of the American Cancer Society.

The Society noted with regret the illness of one of its oldest and most beloved members, Dr. Samuel English, and extended wishes for a prompt recovery.

During the 1947-48 season, the Society lost two members by transfer (Dr. J. E. Shangold and Dr. William Galeota) and gained two members—Dr. W. M. Looloian and Dr. Henry A. Davidson. There was thus no net change in the membership roster, which remains at 33.

MERCER

C. Chester Chianese, M.D., President, Trenton

The Mercer County Medical Society has had a busy season. Meetings have been well attended and interest has been keen. The names of thirty-seven active or associate members were added to our roster.

We report with regret the deaths of Dr. Walter E. D'Arcy, Dr. A. M. Barrows, Dr. Henry Janoff, Dr. Norton Parker and Dr. Frank G. Scammell. The community as well as the Society will deeply feel the passing of these men.

Under the direction of the Program Chairman, Dr. George N. J. Sommer, Jr., the Society enjoyed several interesting and instructive programs: Dr. Arthur H. Blakemore—"Surgical Treatment of Hypertension and Aneurism of the Abdominal Aorta"; Dr. Louis H. Twyeffort — "Psychiatric Problems in Medical Practice"; Dr. Robert Garber—"Admission of Patients to the New Jersey State Hospital"; Dr. Ralph Thompsott—"Newer Aspects of Treatment with the Antibiotics"; Dr. Edward G. Waters—"Modern Approach to Today's Cesarean Section"; Dr. William D. Stroud—"Cardiac Disease in the Aging Patient". The staff of the McKinley Hospital presented a scientific program this year, which was well attended, and well received.

All committees undertook active programs this year. In connection with Public Health Week, the Public Relations Committee prepared an extensive program through an open meeting, health problems were brought to public attention, thus making for better understanding between the medical profession and the public.

Several committees are enthusiastically attacking new problems. The Tuberculosis Committee recommended that more hospital beds be made available for treatment of tuberculosis in this area. The Blood Donor Committee is now negotiating with the Red Cross to settle the local blood bank problem. And now under discussion, are plans to organize a Mercer County Heart Association.

Future activities include the Centennial celebration of the Mercer County Society in May. A dinner-dance is also scheduled for that time. In April the Cancer Control Committee will conduct an open meeting. The work of the Committee on Post-Graduate Training is increasing in scope. In 1947, forty-seven members took the proposed course.

The year has been a most pleasant one for me and I wish to extend a sincere "thank you" to the officers of the society, the committees and the members for their cooperation and support.

MIDDLESEX

Edward F. Klein, M.D., President, Perth Amboy

Perhaps the best report that can be given for a county society is the actual presentation of its program. This speaks for itself. Middlesex County Medical Society held ten meeting during the calendar year 1947. The opening session was devoted to psychiatry for the general practitioner, the essayist being Dr. John M. Cotton of New York. In February we heard Dr. Herbert T. Kelly of Philadelphia, discuss nutrition in psychosomatic medicine. In March we turned to one of our members, Dr. Sylvan Moolton, pathologist at St. Peter's Hospital. He spoke on the normal and abnormal activities of the human spleen. April was devoted to a presentation on regional ileitis, the guest speaker being Dr. Joseph Fobes of New York.

In May, the scientific program was an analysis of laboratory aids in the fluid balance of surgical patients—an interesting topic ably presented by Dr. Francis D. Speer of New York. In June there was a special meeting to discuss the proposed revision of our constitution and by-laws, and this was followed by a joint social-scientific session at the Forsgate Country Club. The members of the Dental Society were our guests, Dr. David Scherf was the speaker, and pulmonary embolism was the subject for this occasion. October was featured by a full business meeting, and November by our traditional joint meeting of pharmacists and physicians. The speaker, Dr. Richard Reager of Rutgers University gave a talk entitled "A Prescription for Professional Speech". At this meeting the revised constitution was adopted. The year ended with our social highlight, the annual dinner. The speaker of the session was Dr. Marjorie Shearon who gave a challenging talk designed *Paradise Unlimited, or The Menace of the Police State.* Election and installation of the 1948 officers took place at this session.

MORRIS

J. Arthur Byrne, M.D., President, Morristown

Meetings of the Morris County Medical Society were held in October, November, January, February, March and April.

We were fortunate to have outstanding speakers and teachers from some of the leading hospital and medical schools in the east present papers of considerable interest to members of the Society. These included:

Dr. J. Lawrence Pool of the Neurological Institute, New York City, on "Brain Injuries".

Dr. William Crawford White, Clinical Professor of Surgery of Columbia University, New York City and

Dr. Walter Brandes, Pathologist to Roosevelt Hospital, who spoke on "Carcinoma of the Gastro-intestinal Tract".

Dr. Langdon Parsons, Visiting Surgeon to the Massachusetts General Hospital, Boston, and

Dr. Harriet C. McIntosh, Roentgenologist to the Woman's Hospital, New York City, who spoke on "Carcinoma of the Uterus".

High point of the year was a dinner meeting held in January honoring 14 gentlemen who have been members of the Society for 35 years or longer. At this meeting an excellent historical review of the Morris County Medical Society was presented by Dr. George H. Lathrope.

Efforts to advance Dr. Schaaf's State Society program for improving school medical examinations is being carried on by the joint work of our committees on school health and child health.

The Society is cooperating with the Council of Social Agencies and has appointed an Advisory Committee to these agencies.

During the past year we suffered the loss of one of our most active members and past presidents, Dr. Byron G. Sherman of Morristown. This Society is much the poorer for his passing and we shall miss him greatly.

A rheumatic heart survey, under the sponsorship of the Morris County Tuberculosis and Health Association, has been approved by this County Society. This survey is to extend over a period of years.

We were honored by the presence of Dr. Royal A. Schaaf, President of The Medical Society of New Jersey, at our June meeting and at our October meeting we had the pleasure of introducing Mr. James E. Bryan, Executive Officer.

I would be remiss indeed if I closed this report without expressing my thanks to the many members of this Society who have served on committees. To mention but a few, Dr. Inglis F. Frost, chairman of our Program Committee, Dr. F. Clyde Bowers, chairman of the editorial board of the county *Bulletin*, Dr. Charles B. Woodman and members of his Cancer Committee, and lastly, my good friends and faithful helpers on the Executive Committee, Dr. Stanley Teskey, secretary, Dr. Earl DeW. Stage, vice-president, Dr. Henry O. vonDeilen, Dr. Jack L. Voss, Dr. Alden P. King, Dr. Francis Benz, Dr. Nicholas A. Bertha and Dr. Francis S. Renna. All of these contributed greatly to the success of our County activities. To Miss Janet Clark, executive secretary, we also extend many thanks.

PASSAIC

Leon E. DeYoe, M.D., President, Paterson

During the past year our activities have been many and varied. Attendance at monthly meetings has steadily improved to the point we can consider excellent. This is due to the outstanding programs presented, the return of our physician-veterans and the increase in membership in our Society.

Through our program committee of which Dr. Wayne W. Hall is Chairman, we have been fortunate in obtaining speakers of pronounced ability in their various fields of scientific research medicine and surgery, whose subjects for discussion embraced the following:

1. Endocrine therapy in gynecology by Dr. Emil Novak.
2. Chest conditions in general practice by Dr. Benjamin P. Potter.
3. Dr. J. J. Stetzer, Jr., addressed our November meeting on the oral manifestations of disease. This meeting was held jointly with the Passaic County Dental Society.
4. Our December session was a joint meeting with the Bergen County Medical Society.

The subject was cancer and Dr. George T. Pack was the principal speaker.

5. Dr. Maurice Lenz spoke on the radiocurability of cancer.

6. Dr. Henry C. Falk, in February, spoke on post-abortal infections.

7. Peripheral vascular diseases by Dr. Teresa McGovern.

8. The Fall Clinical Conferences of The Medical Society of New Jersey were resumed with Passaic County playing host to the clinical high spot of the year on October 29, 1947. We extend due thanks and appreciation to the committee under the chairmanship of Dr. Sigurd W. Johnsen for the success of the conference.

Our cardiac committee in conjunction with the Passaic County Tuberculosis and Health Association again sponsored a successful "Heart Week" in Passaic County.

The Speakers' Bureau has provided speakers for the many requests received by the Executive Office for talks on the various phases of medicine, particularly on cancer.

The Rh Negative Donors Club has continued as a project of the maternal welfare committee. Organized in 1944, the Club now has a membership of 100 donors. Through the committee, cards were also furnished the Hospital Blood Banks and the Board of Health to forward to persons whose blood has been typed informing them of their type and Rh Factor.

The *Bulletin* has been published regularly with many items of scientific and constructive nature along with news of local, state and national interest to the members. I take this opportunity on behalf of the members to express our thanks to Dr. Joseph E. Mott and the members of the editorial staff for their excellent work on our publication.

The post-graduate education committee has been active in arranging and conducting lecture courses in biochemistry, obstetrics and gynecology, pathology of internal medicine and surgical physiology.

The cancer committee in conjunction with the county chapter of the American Cancer Society has held many meetings in an effort to determine the needs of the tumor clinics and to form the program for aid to the clinics and to indigent cancer patients.

The Society has been kept abreast of pending legislation through the publication in our *Bulletin* of bills pertaining to medical practice and public health.

The Woman's Auxiliary has pioneered a Health Council to put into effect the four-point health program sponsored by the State Department of Education and The Medical Society of New Jersey. We heartily commend the Woman's Auxiliary for their splendid efforts and the success of any project undertaken.

On the whole, our County Society has had a very satisfying season, but the year had its sad and melancholy aspects too, when we lost Dr. Howard H. Nye, Dr. William West Sutherland, Dr. Joseph V. Bergin, Dr. Israel Feigenoff, Dr. Walter L. Dunning, Dr. Thomas Glasgow and Dr. William Neer.

It would be impractical to enumerate in detail all the activities of our committees and the Society. I express my thanks and appreciation to the officers of the Society, the members of the welfare council, the chairmen of the various committees and the members for their cooperation, attendance at the meetings and their active interest and assistance in the affairs of the Society.

SUSSEX

Martin I. Kirschner, M.D., President, Vernon

The Sussex County Medical Society has had three meetings thus far. We had the pleasure of having a guest at each meeting. Dr. James Norton, the first vice-president of the State Society, and Mr. James E. Bryan, the Executive Officer of the State Society visited us. The former gave an informative talk on what the State Society is doing and planning to do for the general practitioner, and the latter presented an interesting talk on his duties in presenting the problems of the State Society before the public and other cooperating professional groups in particular.

We also had the pleasure of having as guest Dr. J. Fierstein of New York. He presented some very unusual x-ray plates. These were not only interesting but also educational. His presentation received commendation.

During the past year our Cancer Committee met with lay groups and have arranged for three "screening centers" in the county. One of these at Newton Hospital is equipped to re-

ceive cancer patients. But, being a small county, only two patients thus far presented themselves at the "centers".

We also made arrangements with the Red Cross towards establishing blood donor centers. Detailed agreements were made with the Sussex County Tuberculosis League for the purpose of establishing a center in Newton for "mass x-rays".

For the first time, we have given permission to the Woman's Auxiliary to the State Society, to organize a unit in Sussex County. Organization is now in process.

The attendance at our meetings was very satisfactory and our members are cooperating with the officers, and for this, the president is most thankful.

UNION

Stanton H. Davis, M.D., President, Plainfield

The Union County Medical Society enjoyed a successful and educational year. The Medical Education Committee with the cooperation of Rutgers University arranged a graduate lecture course in medicine which started on January 9. The first eight lectures were given by Maurice Bruger, M.D., Chief, Division of Pathological Chemistry, New York Post-Graduate Medical School and Hospital. The other eight lectures were given by Clarence E. de la Chapelle, M.D., Professor of Clinical Medicine, New York University College of Medicine; Burrill B. Crohn, M.D., Consulting Gastro-Enterologist, Mt. Sinai Hospital, New York; Otto Steinbrocker, M.D., Chief, Arthritis Clinic, Bellevue Hospital, New York; Herbert S. Ripley, M.D., Assistant Attending Psychiatrist, New York Hospital; and Stewart G. Wolf, Jr., M.D., Assistant Professor of Medicine, Cornell University Medical College. Ninety-two members are taking the course and ten interns from the hospitals throughout the county are attending the lectures as guests of the Society. So much interest has been shown that already plans are being formulated to go ahead with another course next year with the idea of having a thirty-two week course starting early in the fall.

It is with regret that I have to report the deaths of Dr. R. A. Shirrefs and Dr. A. T. Murphy of Elizabeth, Dr. J. O. Evans and Dr. H. M. Glasston of Linden, Dr. E. E. Terrell and Dr. R. A. MacBrayer of Summit. The deaths of Dr. Terrell and Dr. MacBrayer were the direct result of their services in the Armed Forces. These members will be missed in the field of medicine and in the civic communities as well. Thirty-four new members were received into the Society this year making a total membership of 448.

Activities of the Legislative Committee are becoming a more important phase of our work each year. As in past years, this committee gave yeoman's service to their Society and the Woman's Auxiliary gave splendid support when called upon to help prevent the passage of bills that would lower the standards of medical practice.

I wish to express in this report, the appreciation of the members of our Society, for the service rendered by Dr. E. T. Yorke of Linden as the liaison officer for the State Society with the Veterans Administration. He handled his work with skill and tact and now that the liaison office has been closed, he is resuming his private practice. We feel that Dr. Yorke will continue to render valuable service to his County and State Society as he is always interested in any phase of medicine and ever helpful when called upon to serve in any capacity.

A new Advisory Committee to the New Jersey Board of Child Welfare was appointed this year. This committee will serve in an advisory capacity to the state and county board. More recently the County Society and the board set up regulations regarding fee schedules.

One of our members has served as chairman of the Health Division of the Council of Social Agencies of Eastern Union County. Through his interest and assistance the County Society endorsed a plan for the care of the long term ill. The endorsement by the Society will facilitate the work of the lay members of the Council in putting on this program and it will be started in the very near future. This is a long range program but we do feel that progress has definitely been made this year.

Public relations continue to improve and

good publicity given the Woman's Auxiliary projects has reflected favorably on the Society as well. More and more of our members are participating in community activities. This is one of the best ways of furthering good public relations. Every year more organizations and individuals are looking to the medical profession for guidance in health problems.

Several projects that were in the discussion period last year have been completed this year. The poliomyelitis unit was opened at St. Elizabeth's Hospital and proved its value immediately. The Cancer Clinic at Overlook Hospital has been opened and the hospital has now become an "Eye Bank" participant. Overlook Hospital's surgical staff has volunteered its services for the collection, at time of death, of fresh human eyes donated in the interest of sight restoration for others. The Cranford area has a walking blood bank which was set up with the cooperation of the doctors and interested lay groups in that area. The Elizabethtown Chapter of the American Red Cross is starting a walking blood bank in cooperation with the Medical Society of Roselle-Roselle Park in response to a request from the doctors. The cancer program now includes nursing care through a grant to the Visiting Nurse Association.

The newspapers in the county have been most cooperative in publishing the news of the Society, its members and of the Woman's Auxiliary. The Cranford *Citizen-Chronicle* has had several splendid editorials on medical questions and the Elizabeth *Journal* published an editorial on the meeting held by the Woman's Auxiliary when Mr. Bryan discussed the Four Point Program for Improved School Health Services. The newspapers have availed themselves of our information service regarding members and have cooperated in checking medical material before publishing it.

The problem of hospital appointments has been one of deep concern to the Society but with the cooperation of the six hospitals in the county, part of this has been solved.

The members of the Society were pleased to have the opportunity of meeting Mr. Bryan when he attended our November meeting. Since his arrival several plans have gained impetus and we will of course cooperate with Mr. Bryan in carrying out his duties for the Society.

The Woman's Auxiliary has had an interesting year and with such an active group, it can be an immense force for good in the county. Last year there were only twenty-nine members. Today the Auxiliary has one hundred thirteen members which highlights the growth of interest in the activities of the Auxiliary.

At the outing held in Plainfield a talk was given by Miss Charlotte McCracken, Director of the Elizabethtown Chapter of the American Red Cross, on the work of the Grey Ladies at Halloran Hospital. As a result, two members immediately volunteered to serve and became so interested in the work that they are now, after special training, teaching arts and crafts to the patients in the hospital. A luncheon meeting was held in November with one hundred guests and members present. Mrs. Lodovico Mancusi-Ungaro, president of the Woman's Auxiliary to The Medical Society of New Jersey and Mrs. Robert Walker, president-elect, and Mrs. Asher Yaguda, chairman of the Public Relations Committee, were the honor guests. A Poinsettia Ball was held on January 17 and was for the benefit of the Student Nurses Fund. It was most successful.

With the endorsement and assistance of the Society, the Woman's Auxiliary is now working on the Four Point Program for Improvement of School Health Services. This is under the sponsorship of the State Board of Education, The Medical Society of New Jersey and the Woman's Auxiliary to the State Society. It started in Union County when the first County Council was held March 3. Representatives of lay groups interested in this program were present and endorsed the program wholeheartedly. We have one of the most active and capable Auxiliaries in the State and we are pleased to give them aid and counsel whenever called upon.

The Executive Office continues to take care of the routine work of furnishing information to the doctors, their patients, various organizations and individuals; placing medical and lay personnel and finding nursing homes both for adults and children. Mimeograph work has been done this year for the Auxiliary in helping them send out notices for their meetings. Material has been supplied to speakers, writers and students on medical subjects as in the past.

Our Executive Secretary continues to represent the Society through organizations requesting representation and is in a position to keep the officers and members informed on matters of interest to them; she is, in turn, in a position to present the viewpoint of the Society. Miss Rogers has attended the meetings of the Welfare Committee of The Medical Society of New Jersey, the Woman's Auxiliary, both county and state, and (with a group of members) attended a meeting of the New

Jersey Women's Medical Association in Princeton last fall. She has been appointed temporary recording secretary to the County Council and continues to edit the *Bulletin*. Several new advertisers have been secured this year and we deeply appreciate the continued support of our advertisers especially those who have been with us since the *Bulletin* was first printed.

To the officers and members of the Society, I wish to express my thanks for their cooperation, their attendance at the meetings, for their active interest in all of our projects and participation in the affairs of our Society.

WARREN

Walter Boquist, M.D., President, Phillipsburg

First meeting of this term was held October 21 in Phillipsburg. Because of the large amount of business, it was decided to hold meetings every other month instead of every three months and to change the hour from 11:00 a. m. to 9:00 p. m. Since this was the Annual Meeting new officers were elected and new committees were appointed.

A joint meeting of the Society with the Woman's Auxiliary was held on January 20. Dr. Zuck, our liaison physician to the Woman's Auxiliary, initiated a panel discussion of the Four Point School Health Program. Taking an active part were three guest speakers:

Mrs. Lodovico Mancusi-Ungaro, President of the Auxiliary to The Medical Society of New Jersey.

Mr. James Bryan, Executive Officer of The Medical Society of New Jersey.

Mr. Will Atwood, Superintendent of the Warren County School System.

A meeting on February 17 was held at the Warren Hospital. This was highlighted by a discussion of the medical care at the County Welfare Home. The Society then approved of a committee to assist the Welfare Board in the health care of these patients. The scientific program of this meeting was presented by Dr. David Feinberg, Pennsylvania. His topic was "Psychosomatic Medicine".

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New Brunswick	....	....	10:54	3:46	7:37
Princton Jct.	7:50	....	....	4:02	7:54
Trenton	8:01	10:00	11:23	4:18	8:05
Burlington	....	....	11:45	4:40	....
Haddonfield	9:02	....	12:12	5:12	9:12
Atlantic City	10:03	12:00	1:05	6:04	10:13
	A.M.	Noon	P.M.	P.M.	P.M.

The first of the above trains does not operate on Sunday. The others do.

BOOK REVIEWS

Rh—Its Relation to Congenital Hemolytic Disease. By Edith L. Potter, M.D. 344 Pp. Year Book Publishers, Chicago, 1947. $7.50.

Dr. Potter has done a commendable job in assembling vast material, much of which is not sound scientifically. It is to her credit that she was not misled by the numerous claims which were recently made such as proteins, conglutination, pathogenesis of kernicterus, clinical correlation of symptoms depending upon the presence of agglutinins or blocking antibodies, and congenital malformations induced by iso-immunization. The first four cover the historical background of individual blood differences, the discovery of the new blood factor and the series of events which led to the serological and genetic complexity of the Rh factor.

The reviewer must take exception to Potter's stand on the mechanism of transplacental iso-immunization. It is highly probable that early abortions, and complications of labor do not by themselves play essential roles in transferring fetal blood into the maternal circulation. Since all workers are agreed that minute quantities of fetal blood suffice for iso-immunization, such passage may occur during the course of every normal pregnancy. In this connection the occurrence of erythroblastosis fetalis in the first born is important, independent of the influence of previous intravenous or intramuscular injections of blood. The author does not sufficiently appreciate the antigenic properties of blood administrated either by subcutaneous or intramuscular route.

Potter contributes a service in taking a stand that aside from the role of the Rh factor in erythroblastosis fetalis and transfusion accidents, the Rh factor is not related to abnormalities of pregnancy or conditions of the fetus or newborn infant other than erythroblastosis fetalis. The several claims regarding congenital malformations, abortions, premature separation of the placenta are not supported by the results of statistical studies.

The author's long experience with newborn infants is reflected in the excellent sections on erythroblastosis fetalis. There are numerous illustrative photographs of the gross and microscopic pathology which should be of considerable help to the practitioner. In the section on treatment of the affected infant with transfusion of Rh negative blood, no mention is made of the precipitin test for the differentiation of those infants who must receive intensive therapy and perhaps a replacement transfusion from those who require one or two transfusions. The test is however referred to elsewhere in the text. The reviewer can only applaud Potter's view that exsanguination transfusion should be limited to carefully selected cases. Potter offers the excellent suggestion that the circulation through the cord of affected infants be interrupted immediately after delivery.

Dr. Potter has accomplished an enormous task and produced a monograph which will be of great help to the reader.

PHILIP LEVINE, M.D.

War Stress and Neurotic Illness. By Abram Kardiner and Herbert Spiegel. 428 pages. New York, 1947. Paul B. Hoeber, Inc. $4.50.

Many psychiatrists still cling to the glib theory that a battle neurosis is structurally the same as any other psychoneurosis, and that it requires the same kind of handling. In the present work, Kardiner and Spiegel carefully and completely demolish this oversimplification. They trace the battle neurosis from its onset, through its acute phases, past the subacute stages, and into its well entrenched chronic form. The psychopathology and dynamics of each step are compactly detailed and supported by a varied reservoir of clinical case studies.

The distinction is not something merely of academic interest to psychiatrists. It is of intimate importance to any doctor who has the practical problem of treating a patient who has developed a train of "nervous" symptoms following an injury or the threat of an injury. According to the orthodox theory, these traumatic neuroses are simply ordinary psychoneuroses in which the trauma acted as a symbol and revived old emotional conflicts. That this is not so is convincingly demonstrated by Kardiner and Spiegel. They show that a combat (or industrial) trauma constitutes a "real" (not symbolic) threat of annihilation. The way in which the personality reacts to this threat is detailed in an account as absorbing as an adventure story.

Therapeutic technics are discussed, though they are not presented in the one-two-three detail which would be required in a guide to treatment. For instance, the authors appraise the value of the barbiturate interview (they think its claims are exaggerated) but they do not tell the reader the dosage or the technic. They evaluate the role of psychotherapy and hypnotherapy, but do not describe the procedures. This omission is not a serious defect, however, since we already have access to a large literature on treatment technics in psychiatry.

The text is readable, though there is no shortage of psychiatric jargon. This arises not out of the authors' desire to be impressive, but out of the fact that the more esoteric concepts of psychodynamics cannot be expressed in basic English. Few non-psychiatrists, for instance, will find much information in sentences like ". . . based on a conative striving, rather than on a structural principle. Psychoanalysis is an atomistic psychology which attempts to derive complex entities from a synthetic principle." And the physician who is not psychiatrically oriented will find it hard to hack his way through a sentence like ". . . libido stasis in the form of inadequate gratification can lead to the genesis of free floating anxiety." However, no accurate presentation of psychopathology is possible without the special lexicon which the subject requires, and the physician who really wants to understand these things will find no short-cut anywhere. This volume has to be *studied;* while it is free of much of the obscurantism of certain other psychiatric texts, it cannot be expected that it will be as easy to read as Mother Goose.

Who will find it worth-while to study these pages? The answer is simple: any doctor who treats veterans or who has to handle workmen who have suffered from industrial accidents. It will give the reader a rich insight into what actually goes on in the mind of the person whose symptoms have resulted not from the injury but from a knowledge of the fact that he has been exposed to an injury. To the physician who really wants to understand this large group of patients, a careful reading of the Kardiner-Spiegel text will pay rich intellectual and professional dividends.

Henry A. Davidson, M.D.

Advances in Pediatrics, Volume II. Edited by S. Z. Levine, A. M. Butler, L. E. Holt, Jr., and A. A. Weech. New York, Interscience Publishers, Inc., 1947. $6.75.

Thirteen recognized authorities in pediatrics have collated the most recent information on such timely subjects as antibiotic therapy, congenital malformations, role of fluorine in dental caries, factors determining the growth of children, virus diarrhea, atypical pneumonia, infectious lymphocytosis, prematurity, prevention of recurrences of rheumatic fever, and the genesis of hyperbilirubinemia.

In one of the most stimulating chapters, Warkany discusses the newly developed science of teratology, and the hereditary, nutritional and chemical factors related to congenital malformations. He points out that the weight of the body increases 27,500 times per week during the first eight weeks, while it increases only .02 times in the post-natal period. "Because of the rush of early developmental processes, errors are bound to occur and the chances of repair are slim."

The information about streptomycin is incomplete and there is only a short comment about its toxicity. In the treatment of chronic meningitis, the use of heparin intrathecally is recommended as a valuable adjunct in reducing the amount of fibrin formation and the resulting hydrocephalus.

Primary virus pneumonitis is defined as a specific, highly contagious disease, in which inclusion bodies are found in pharyngeal cells of most of the sick infants examined. In the retrospective diagnosis of primary atypical pneumonia, the cold hemagglutination of red cells and the agglutination of streptococcus M.G. are valuable aids. The epidemiology and the differential diagnosis of this disease are discussed in detail.

Talbot and Sobel discuss the increasingly important subject of growth and development. The organism must be in "positive balance" with respect to nitrogen, calcium, phosphorus and potassium, for the construction of new protoplasmic tissue. Johnston has long advocated the increase of protein, calcium and vitamin D in the diets of adolescents. The various endocrines controlling growth are fully discussed.

The physiology and handicaps of premature infants are presented in an interesting manner. Use of protein milks and the early institution of vitamins are advocated. Retrolental fibroplasia is apparently more frequent in infants who are less than three pounds at birth. Searching nystagmus and apparent photophobia are the clinical signs. In well developed cases, there is opaque vascularized tissue behind the crystalline lens in which the vessels tend to radiate from a central point.

This volume is recommended to all physicians who treat children. The subjects presented are completely reviewed and the bibliography is extensive.

Nathan Zukerberg, M.D.

Stereoscopic Atlas of Neuro-Anatomy. By H. S. Rubinstein and C. L. Davis. Forty-three stereoscopic photographs with an eighteen-page instructional brochure. 1947. Grune and Stratton, New York, $10.

For the physician equipped with a small hand stereoscope, this is the ideal guide for the study of neuro-anatomy. The set consists of 43 plates plus an explanatory pamphlet. Each plate contains two stereoscopically placed photographs, with a well labelled line drawing above the line of vision of the stereoscope. Beginning with embryology, the atlas progressively traces the development, structure, dissection and function of the central nervous system. The first five plates are devoted to fetal structures. The remaining thirty-eight deal with various aspects of the external configuration and internal structure of the adult brain. On the whole it is a practical substitute for the actual brain itself, since most physicians find it hard to get hold of a brain for study purposes, and harder still to dissect the organ systematically and relate their findings to actual anatomy. The atlas represents one of the few really new ideas of the century in neurologic bibliography.

E. Hirrschoff, M.D.

Physicians Handbook. By John Warkentin, Ph.D., M.D., and Jack D. Lange, M.S., M.D., 4th ed. Pp. 282. Chicago, Illinois, University Medical Publishers. 1946. $1.50.

This is a good handbook for rapidly ascertaining facts in laboratory diagnosis or clinical procedures. The first part of the book contains the laboratory diagnosis, and the second section outlines the clinical procedure and facts.

Included are all testing methods for body fluids and excretions; function tests; serodiagnosis; communicable diseases; bacteriology.

In the second part are described clinical procedures and facts, such as: circulation tests, pre- and post-operative care, parenteral fluids, dietary requirements, diabetic treatments, useful drugs and solutions, etc.

The book is small and the facts concisely given. It should be handy for the practitioner for refreshing his memory on details of procedure, and as a pocket manual, indispensable to the intern or resident.

Ralph Tuly, M.D.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **April, 1948** **No. 4**

IT IS well to be reminded how great a contribution tuberculosis-conscious physicians can make to preventive measures against tuberculosis in the discharge of the ordinary duties of a general practice. As it becomes more generally recognized that any patient who consults a physician for any reason may be a case of tuberculosis a long step will have been taken toward the final eradication of the disease.

CASE-FINDING

Modern case-finding is without doubt one of the chief factors in the battle against tuberculosis. It began with emphasis upon contact examinations and extended to mass community-case-finding techniques. Now roentgen technique, particularly as exemplified by the miniature film, is in danger of crowding out other important diagnostic measures, notably tuberculin testing.

Nevertheless there are enormous difficulties in the way of procuring periodic chest films for everybody. Expense is one thing; personnel is another. Cooperation on the part of the public, while less tangible, is not to be ignored. As an experiment, total community surveys have been made and are now being undertaken by the Tuberculosis Division of the United States Public Health Service. Meanwhile it would seem that other efforts, which attempt to focus roentgen case-finding technique, should not be neglected.

Fortunately it has long been recognized that tuberculosis is distributed in more or less well-defined patterns. It is more prevalent among the underprivileged; and therefore, in groups whose housing and nutrition are bad. There is evidence that other not well understood biological factors may also play an important role in morbidity and mortality characteristics. Numerous observations suggest that these factors are extremely subtle in their action. Among these may be mentioned the fact that the Chinese of San Francisco have a death rate from tuberculosis between three and four times that of the white population, while the Japanese of the same city, in the year before World War II, had a death rate less than that of the white population. Among the white population the death rate increases in inverse ratio to economic status. Case-finding studies, therefore, yield rich returns when directed toward special population groups, with a high incidence of tuberculosis.

Recently it has been recognized that general hospitals and clinics normally operate as concentrating mechanisms for cases of tuberculosis. Less consideration has been given the offices of the general medical practitioners. A pilot study by Dr. Albert C. Daniels, then in private practice in California, suggests that an alert general practitioner can contribute measurably to the solution of the tuberculosis problem in his community. While the figures are small they are nonetheless suggestive. Between October, 1941, and April 1942, Doctor Daniels routinely fluoroscoped 250 patients. This included all new patients who passed through his office during this period. Films were taken of all patients who showed suspicious findings on fluoroscopy. Seven active cases of pulmonary tuberculosis were discovered in this group of 250 patients, a prevalence of 2.8 per cent. They varied in age from 18 to 57. None gave a history of close contact. Only one suspected that he might have tuberculosis; only one had physical signs suggestive of pulmonary disease.

In the seven previous years of general practice, Daniels had discovered only five active cases of pulmonary tuberculosis. Other physicians of the community, queried by Daniels, had discovered one or two active cases of pulmonary tuberculosis a year. Nevertheless, in this community, statistics suggest that approximately 30 per cent of the general population consult some physician during the year for some complaint.

Daniels assumed at this time that the prevalence of clinically significant tuberculosis in the population at large in his community was one per cent.

This would have meant that there were approximately 500 cases existing in the county. If the prevalence of 2.8 per cent of active cases in his practice was generally applicable to other doctors' offices, then in the 15,000 patients who consulted doctors there should have been about 400 cases of tuberculosis, or about four-fifths of the active disease in the community. It is at once suggested that a modern case-finding program carried out by general practitioners by any recognized roentgen technique would go a long way toward the solution of the local tuberculosis problem.

If it is recognized that clinics, general hospitals and doctors' offices represent great natural sieves for the collection of tuberculous individuals, there is present here an extremely economical method of attack.

It would seem that the general practitioners' offices are the great neglected field for case-finding and may prove to be one of the most economical and satisfactory places for further effort. The crux of the matter lies in establishing cooperation between tuberculosis associations, the Public Health Services and organized medicine. This may seem a difficult task, yet its full accomplishment would draw into active cooperation in the antituberculosis movement every general practitioner of medicine in the United States.

A serious weakness in many case-finding techniques has been their inclusion of such a large part of the healthy segment of the population. Preliminary figures derived from 350,000 miniature films taken in California during the past year reveal a prevalence of only half of one per cent or about one-sixth of the Daniels figure. A further weakness is the periodicity of these techniques. Hospitals, clinics and physicians' offices furnish a constantly functioning service that should not be neglected.

Case-Finding, Sidney J. Shipman, M.D., Editorial, The American Review of Tuberculosis, December, 1947.

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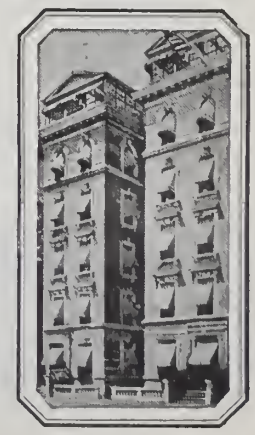
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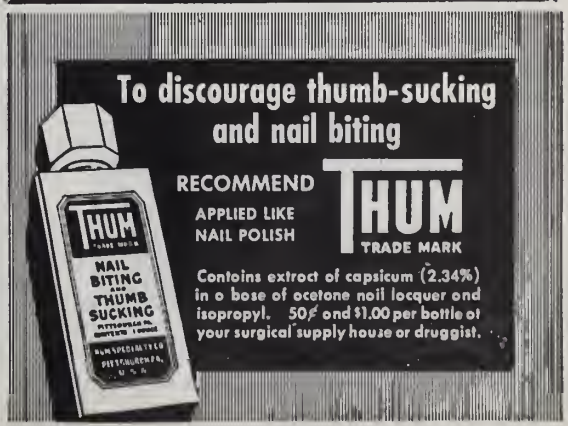


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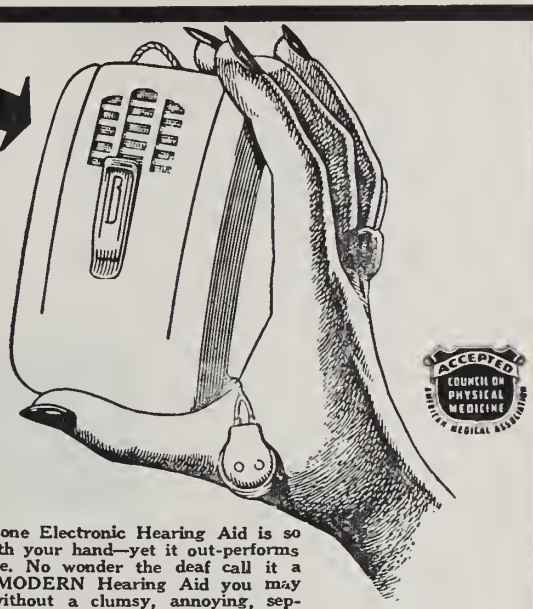
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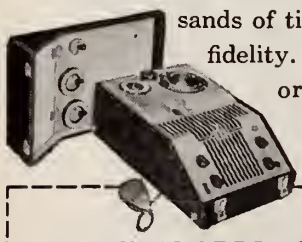
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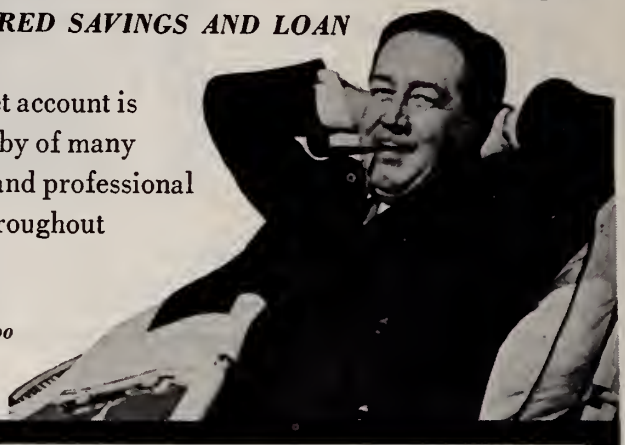
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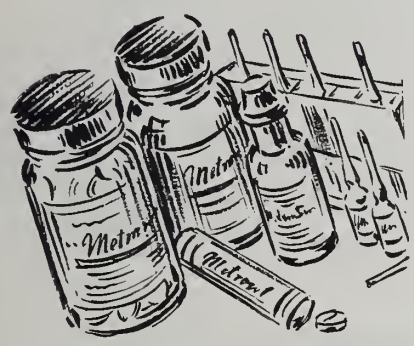
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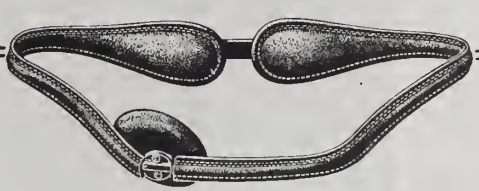
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OF

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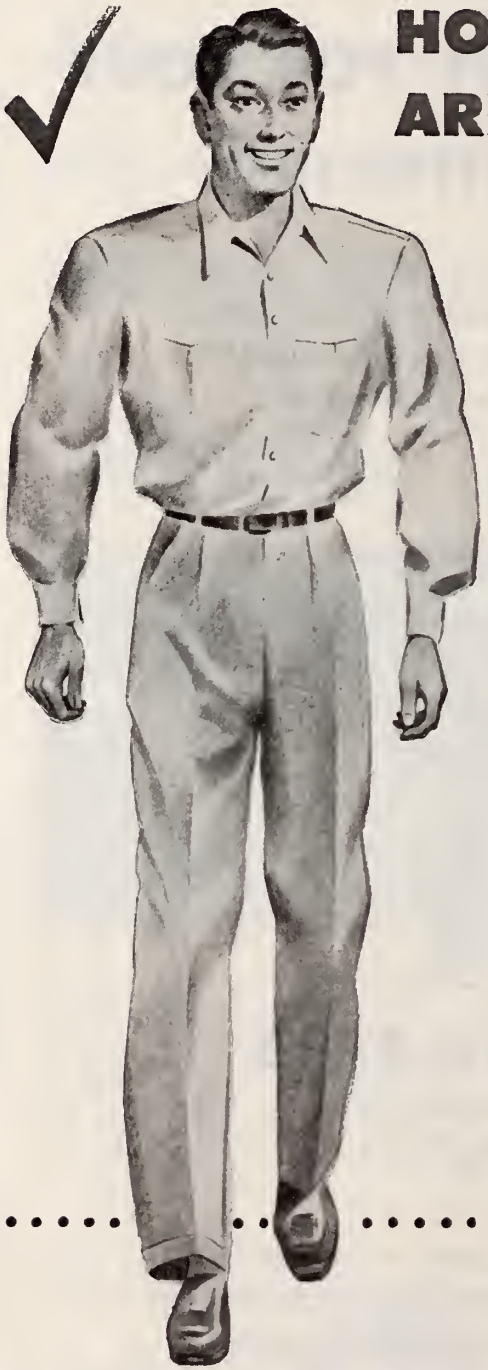
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Amniotin is well tolerated. It is readily metabolized by the body, and detoxified by the liver. Moreover, the natural estrogens in therapeutic doses are less likely to induce menopausal bleeding or hyperplasia of the endometrium.[3]

Whether symptoms are mild, moderate or severe, oral and intramuscular forms of Amniotin in a variety of potencies fulfill every need. Capsule suppositories are also available.

BIBLIOGRAPHY:

1. *Texas State J. Med.* 52:683 *(Apr.)* 1947.
2. *J. Clin. Endo.* 3:89 *(Feb.)* 1943.
3. *J.A.M.A.* 134:1141 *(July 26)* 1947.

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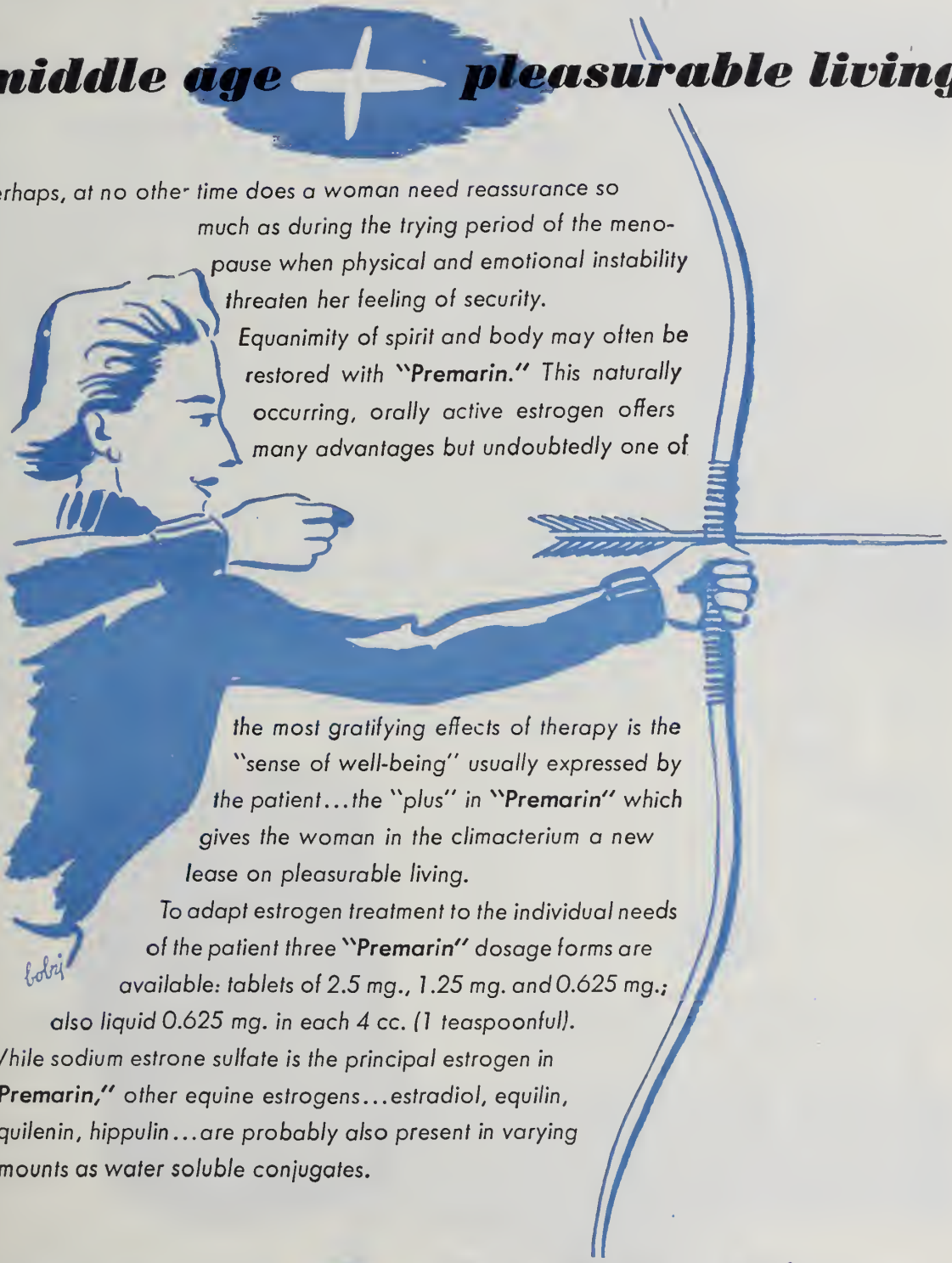
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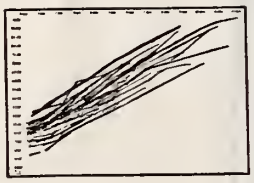
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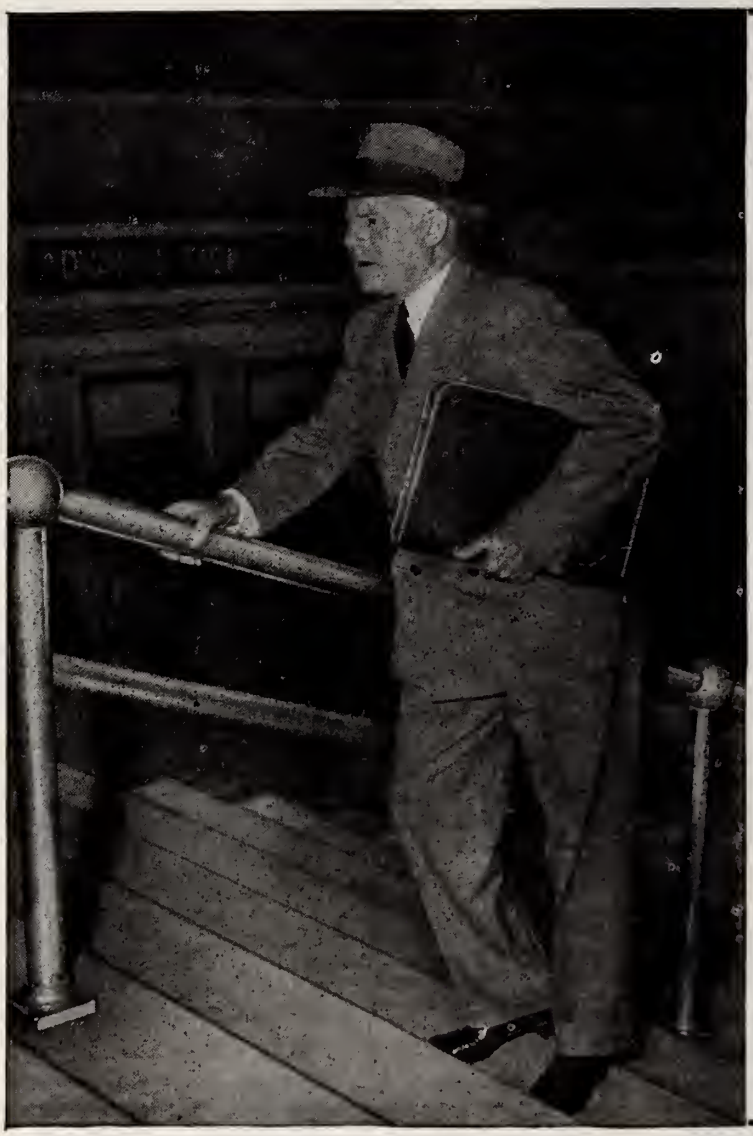
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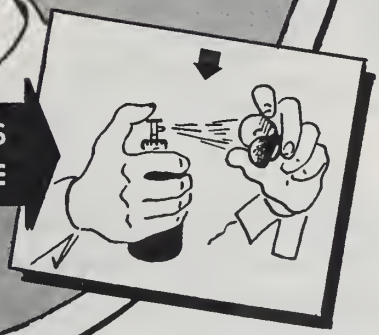


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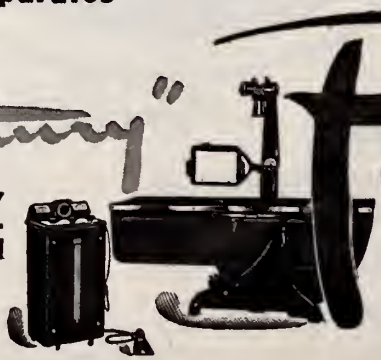


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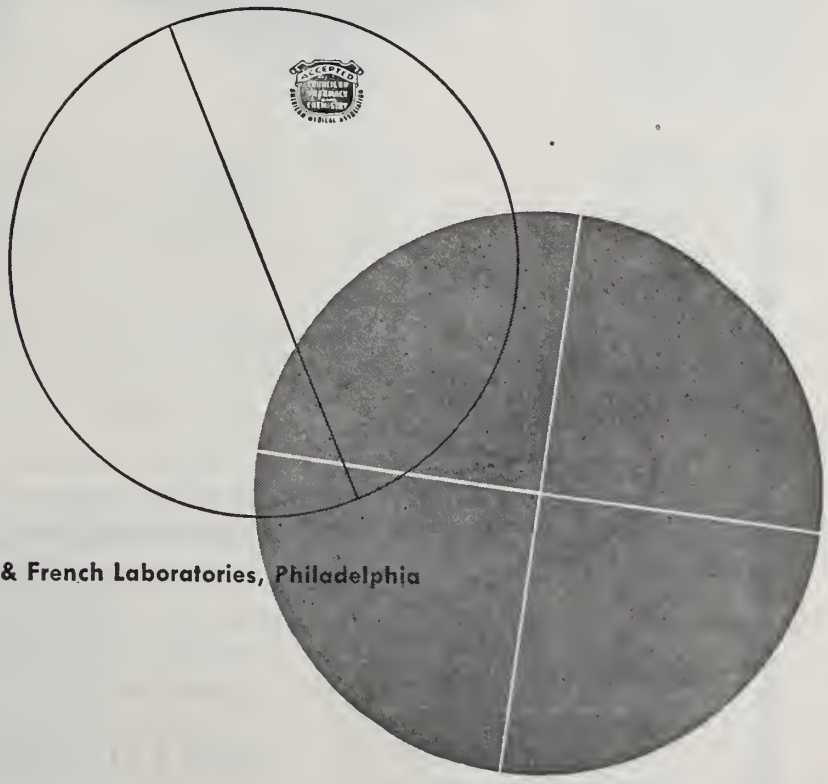
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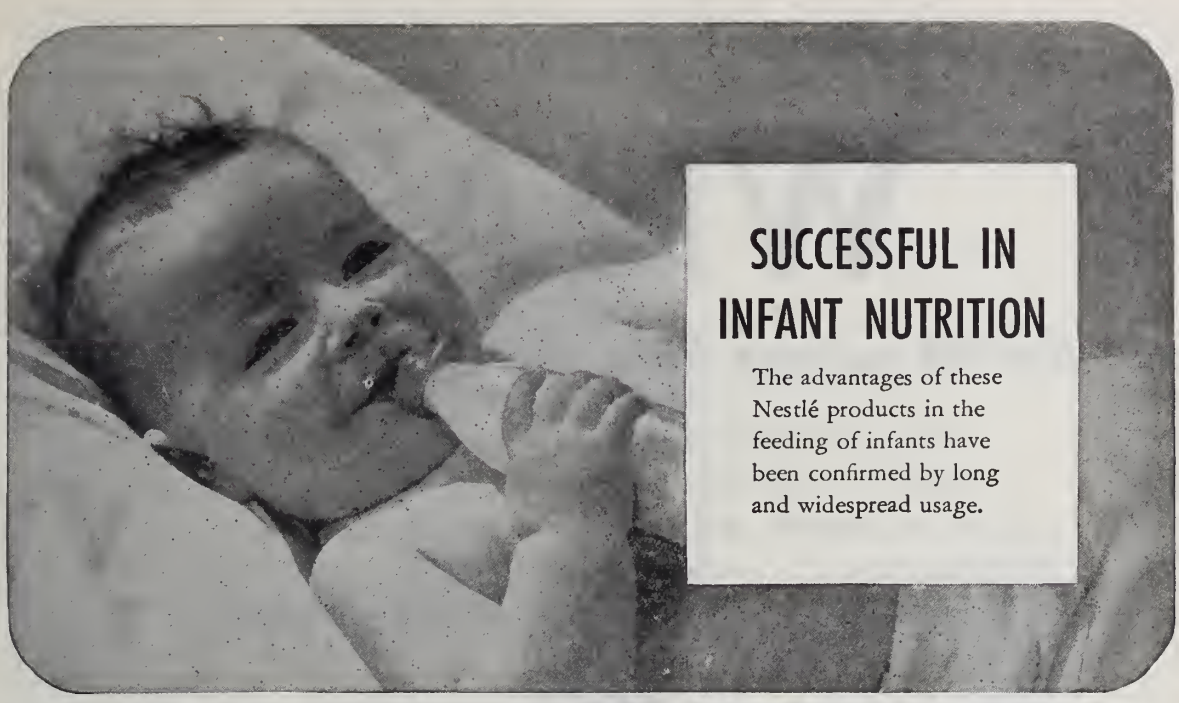
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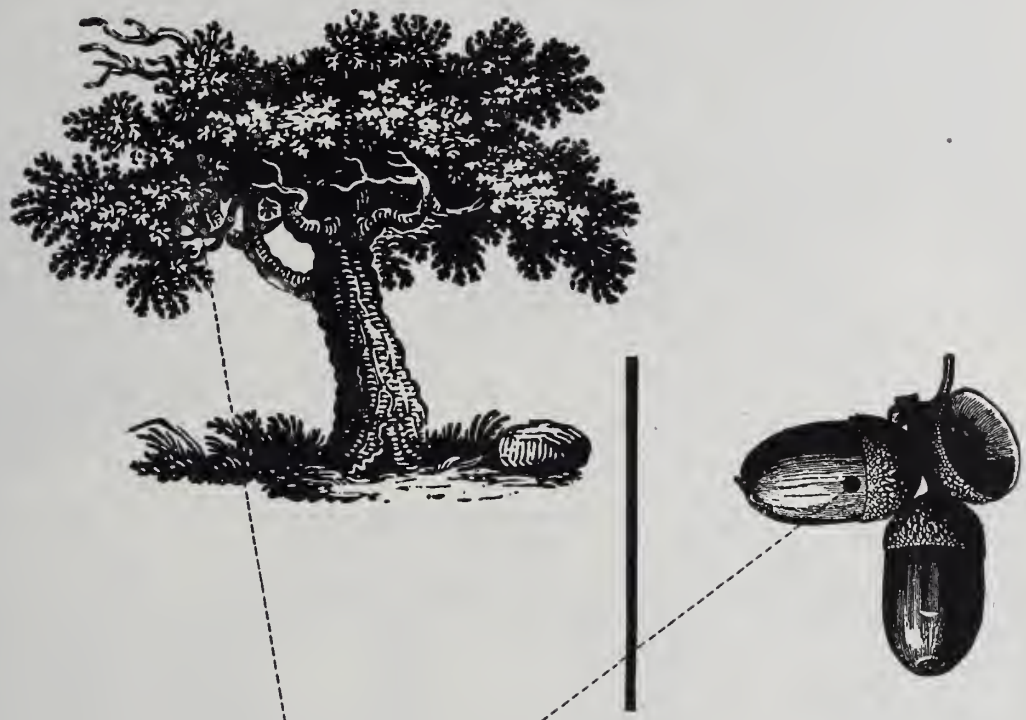
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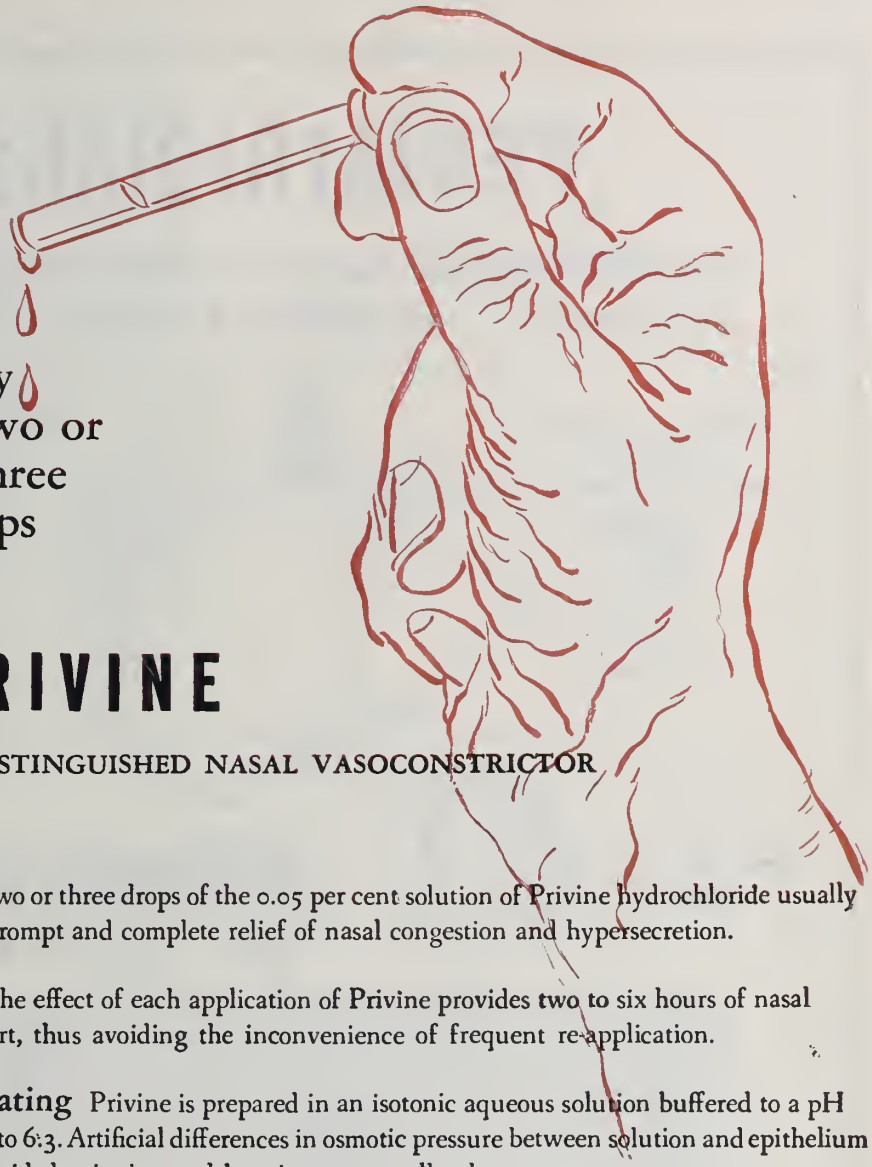
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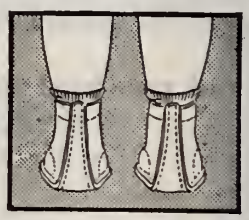
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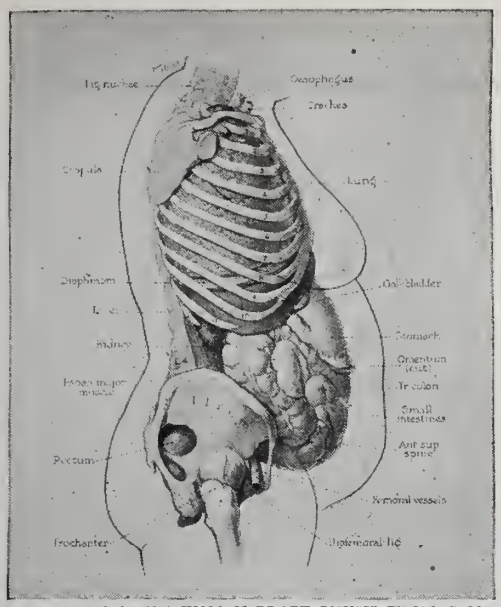
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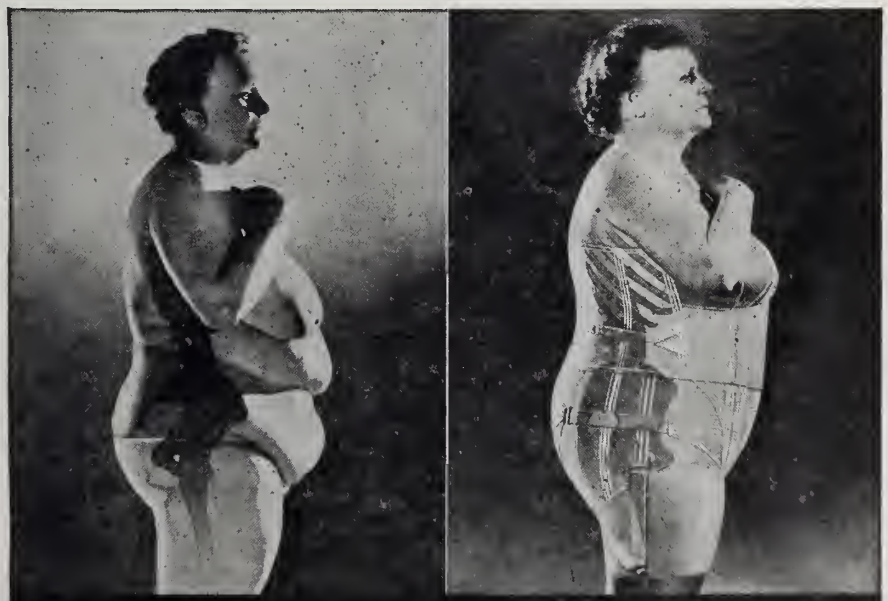
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1. Zondek, H.: The Diseases of The Endocrine Glands, ed. 4 (Second English), Baltimore, Williams & Wilkins Company, 1944, p. 421.

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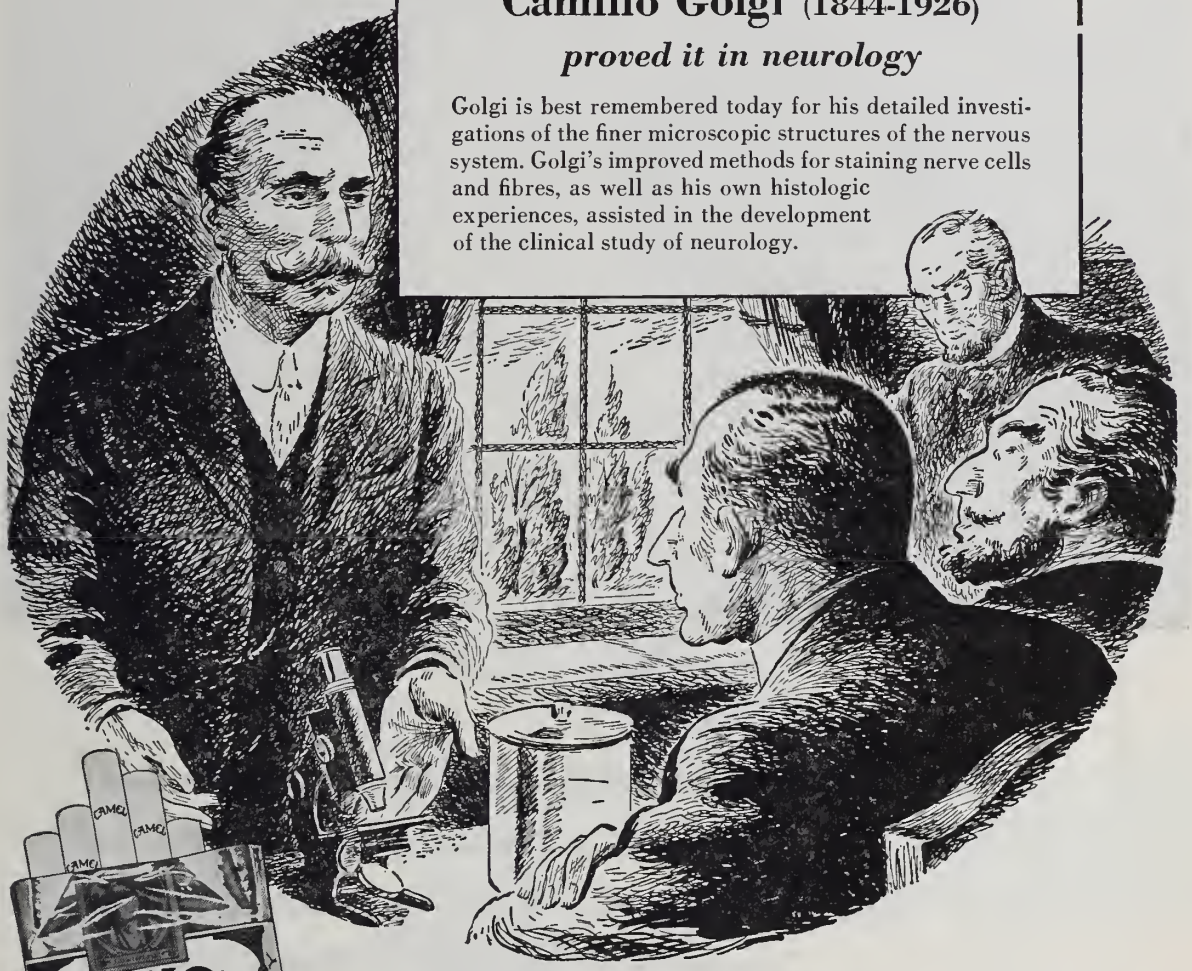
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OUR NEW PRESIDENT



Jennings Howard Hornberger, M.D., was born June 11, 1896, in Mt. Pleasant Mills, Snyder County, Pennsylvania. He was the elder of two children born to Jerome W. and Maria M. Hornberger. His early education was received in the public schools of Milton, Pennsylvania.

He attended Bucknell University, from which he received his B.S. degree. He was graduated from the University of Pennsylvania Medical School in 1921. He was resident physician at the Philadelphia Hospital and later at the Philadelphia Hospital for Contagious Diseases.

On July 1, 1923, he became associated with the John A. Roebling's Sons Company, Roebling, N. J., as physician to their plant, in addition to conducting an office for general practice. He is now assistant medical director of the company in charge of the Roebling plant.

He married Leah M. Lewis, a graduate nurse, in 1925. They have three children, Jeanne M., Joan P., and Robert H.

Dr. Hornberger is medical examiner for the Florence Public Schools and physician to the Florence Board of Health. During the war he was chief physician to

the local draft board in Bordentown, and relieved several local physicians in industrial and health positions.

As a member of the Burlington County Medical Society, he has worked on many committees, and served as president for two successive terms. He has been a member of the Board of Trustees of The Medical Society of New Jersey for the last sixteen years.

Dr. Hornberger's hospital affiliations include the Burlington County Hospital in Mt. Holly, and Mercer Hospital in Trenton. In 1944 the Board of Freeholders appointed him to the Board of Managers of the Burlington County Tuberculosis Sanatorium. His fraternal organizations are the Masons, Shriners, and the Elks. He is a member of the Burlington County Country Club.

For many years Dr. Hornberger has been interested in hunting. This is his chief means of relaxation, and he purchased a farm near Roebling several years ago where he now lives, raises pheasants, and hunts whenever he can take time out from his work.

A RURAL HEALTH CENTER FOR NEW JERSEY

The hasty traveller thinks of New Jersey as a factory-lined concrete highway connecting New York with Philadelphia. Even the old-time resident of the urban and industrial sections of the state may not realize that most of New Jersey's area is rural. There are vast stretches of forest throughout Morris and Sussex, acres and acres of clear land in Burlington and Ocean, fat and fertile hills in Hunterdon and Warren. The state sells 120 million dollars worth of farm products a year.

Although most of New Jersey is rural, our health problem has never seemed as acute as it is in some of the less prosperous and more rural states. This is due, in part at least, to the small area of the state and the excellent network of paved highways, which places every cross-roads village within an hour's ride of a hospital. Yet New Jersey does have a rural health problem. This is highlighted by the recent study of health needs in Hunterdon—the only county in the state without a general hospital. It is likewise (and presumably as a result) the only county without a single medical or surgical specialist, the only county where so large a proportion (85 per cent) of its physicians have no hospital connections. Hunterdon has no organized services for blood transfusion, no registry of nurses, no public immunization service, no facilities for the care of contagious diseases. This situation could be duplicated in many counties throughout the nation and symbolizes the nature of the rural health problem.

Hunterdon has moved towards a solution of the problem in a characteristic American way. This is described on page 256 of this Journal. Clamor for improvement came first from the County Board of Agriculture—surely a grass roots origin if there ever was one. This led to the engagement of an expert on health and hospital problems who surveyed the county, analyzed the needs, and offered a constructive, workable solution. The unique feature of the proposed project is the affiliation of the new rural hospital with a grade A medical school. The school will participate because it thus obtains an opportunity to train students, residents and interns in rural medicine—something that is rarely available to an urban medical institution. In return it will assure the new hospital a constant supply of well qualified interns and ready access to the consultative and specialty services of a large medical center. The

need was recognized locally, the solution worked out locally, and most of the funds will be raised locally. The federal government will probably contribute one-third under provisions of the Hill-Burton act, but the major share of both financial support and supervisory control, will rest with the people of Hunterdon county. It is a striking example of what can be done in a health-conscious progressive and reasonably prosperous community. It underscores the soundness of the position taken by The Medical Society of New Jersey on federal aid—the position that such aid should be extended to states which, by reason of their own poor financial position, must have it; but that it is not necessary in the more prosperous areas of the country.

This unique project will be watched with interest, not only by New Jersey physicians and sociologists, but by all throughout the country who are interested in national health. New Jersey has pioneered in other health projects ranging from certified milk to the home-town care of veterans. Add now to that list—rural health facilities with university affiliation.

FORTY MILLIONS FOR FREEDOM IN MEDICAL EDUCATION?

American medical schools today are spending in excess of $43,000,000 annually. But if they are to train students adequately in all phases of medical science, they will need to increase their budgets by at least $40,000,000. This was the burden of a sobering statement made by Dr. Alan Valentine at the recent Annual Congress on Medical Education.

Dr. Valentine and other speakers were unanimous in the belief that if unfettered progress in medical education is to be continued, privately supported schools must receive greatly augmented private support. Federal funds for medical education, except on a short-term emergency basis, were to be considered only as a last resort.

Forty million dollars sounds like a lot of money, but if that is the price of maintaining free, voluntary medical education in the United States, it is cheap indeed—even though it represents nearly a 100 per cent increase over the existing cost of medical education in the United States. When we are reminded, however, that $40,000,000 is only one-fifth of what Americans spend annually on vitamin pills and less that 1/25th of what they spent on jewelry in 1946, then the deficit is not so impressive. Can we afford to "save" $40,000,000 (1/6000th of our gross national income) at the risk of impairing the integrity and independence of American medical education?

DR. CHARLES H. SCHLICHTER 1875-1948

News of the death of Dr. Schlichter reached us as we were about to go to press. We all saw him at the Annual Meeting on April 27—as alert and keen as ever. It was a shock to learn that he had passed away on the evening of April 28. His stature in New Jersey is evidenced by his recent receipt of the Edward J. Ill Award. The rich range of his services is reflected by the roster of the agencies which, at one time or another, he headed—the New Jersey Society of Surgeons, his city's Board of Water Commissioners, the Elizabeth General Hospital, the Public Library, the state's Procurement and Assignment Service. He belonged to that too small but infinitely precious company of physicians who combine devoted service to patients with energetic performance of civic duties.

ORIGINAL ARTICLES

THE CANCER PROGRAM IN NEW JERSEY
Part IV. Financial Aid for Services to Cancer Patients

Prepared by the Advisory Committee on Cancer Control, The Medical Society of New Jersey*

PRIVATE PHYSICIAN KEY PERSON IN CANCER PROGRAM

Real strides have been made in the cancer control program in New Jersey since the publication of Part I of a series of three articles dealing with its various phases.

The program of cancer activities in New Jersey differs somewhat from plans now in force in other states. We make use of the general practitioner as the key person in the cancer detection program. The Medical Society of New Jersey through its Advisory Committee on Cancer Control in cooperation with the American Cancer Society, New Jersey Division, Inc., has circularized every practicing physician in the state and as a result of replies, has prepared a list of physicians ready and willing to conduct complete health maintenance examinations and thus render the cancer case finding service as a part of their office routine.

As long as general practitioners will do thorough physical examinations to the satisfaction of their patients, the necessity for a large number of detection clinics will be obviated. The present plan may not be perfect. It is offered in the spirit of an earnest desire to help all those who seek complete health maintenance examinations for the detection of cancer. In laying plans for future cancer control activities every effort is being made to bridge the gap for the general practitioner in discharging his responsibility to the public more effectively and more completely.

DEVELOPMENT OF CANCER CLINICS

In carrying out completely the cancer examination program in the office of the private physician, several deterring factors were observed such as certain patients' inability to pay for some of the laboratory and x-ray procedures. Not infrequently, laboratory and x-ray services are not available in the general practitioner's private offices.

The physicians of New Jersey were glad to endorse therefore the movement toward the creation of cancer clinics sponsored by The Medical Society of New Jersey in cooperation with the general hospitals of New Jersey. The movement has gained momentum—there are now thirty clinics in operation—and has shown qualitative administrative improvement. This progress is attributable to the availability of funds (raised by the American Cancer Society), to the resumption of private practice by many returning physicians, and to a gratifying increase in interest in the subject during the last decade.

Every effort has been made to encourage proper clinic organization where a general hospital showed interest in cancer activities. Every reasonable request for funds intended to improve cancer diagnostic and therapeutic equipment and enlarge clinic services, was granted.

PROBLEMS IN APPROVING MEDICAL PROJECTS

It was inevitable that in our democratic approach to the cancer problem a great diversity of medical projects should result. Individual hospitals had different problems and needs. The suggestion was made in our September 1946 article [1] that those concerned with drafting medical projects for cancer clinics, communicate with members of the Advisory Committee on Cancer Control and the Medical Director of the American Cancer Society, New Jersey Division, Inc. When this is done, exact clinic needs are assessed on the spot and a proper decision taken with the added assur-

* Dr. William O. Wuester is chairman and Dr. Otto R. Helters is vice-chairman of the Committee. Members of the Committee are Doctors J. I. Echikson, J. B. Faison, H. W. Jack, J. H. Kler, F. W. Konzelmann, T. B. Lee, W. J. Marquis and Leonid S. Snegireff. Consultants are Dr. Raymond V. Brokaw and Emil Frankel.

1. JOURNAL of The Medical Society of New Jersey, 43:360 (September, 1946).

ance that the project meets the prerequisites of the State Plan and hence is acceptable at state and national levels.

Much to the detriment of the whole program some of the medical staffs chose to tackle each problem in their own individual manners without regard to the overall program in New Jersey. Some hospitals submit cancer projects which would essentially serve to reduce current hospital financial obligations rather than produce improved cancer services or offer new diagnostic facilities to eligible cancer patients.

In one or two counties for some unknown reason, there developed a mistaken notion that cancer funds were limitless and that the American Cancer Society was giving money away to hospitals. This resulted in a minor flood of requests from hospitals and a city health department. Projects have also been submitted involving clinic personnel costs ranging from $5,000 to $21,000.

It was necessary therefore to scrutinize carefully all applications for projects, (some of which reflected poor insight into the cancer problem) and return many of them for reconsideration.

If we are to have a coordinated program of cancer control activities in the state, we must have an orderly development of clinics following a reasonable pattern. The alternative is confusion with clinics growing chaotically, sponsoring questionable projects based on little more than the whim of a certain few.

We intend to approve only those projects which will benefit cancer activities—not general hospital needs *per se*. We have a public trust to discharge: to see that cancer funds produce a dollar's worth of service for every dollar expended.

As medical men we have agreed to tell the laymen "when, where and for what purpose money should be spent". Along with rigid adherence to our part of the understanding we must set an example by clearly thinking the medical projects through, before they become recommendations of the executive committee of a county chapter, American Cancer Society, New Jersey Division, Inc., We must scrupulously screen each project so that it is most economical and most effective in meeting cancer patient's needs and cannot be criticised under the general term of lavish spending. We are aware of the dangers of false economy and strive to avoid it.

It behooves us to assist the laymen in every county to spend money on sound cancer activities rather than attempt to minimize or ignore a problem or to deny its existence. It is our duty to encourage the laymen in their quest for complete health maintenance examinations. It is our duty to stress the hopeful side of cancer therapy.

If the attending physician has a hopeless outlook on cancer, what can a prospective cancer patient expect other than discouragement and thoughts of imminent death? Where would we all be today, if our scientists had taken a hopeless view of the problem of atomic fission?

As private practitioners we can ill-afford the luxury of ignoring public demand and public interest in the cancer problem whether it be in Pennsville or Little Silver or Newark or Jersey City. Public impression is cumulative and what affects physicians in one area, reflects on the profession everywhere.

NEED FOR SUBSIDIES TO CANCER CLINICS

It is a common experience that a cancer clinic requires some form of subsidy if it is to serve adequately a large number of indigent patients. The problem becomes even more pressing where the clinic admits (on referral by private physicians) a large group of people, who for lack of a better term, are commonly called the "medically indigent". Because of the circumstances peculiar to New Jersey where the family physician is the main-stay of the early cancer case finding program, the plan of rendering efficient service to patients in modest circumstances or those who are "out and out indigent", is a problem of serious moment in several of the counties.

To encourage the hospital staffs in the proper development of a good and efficient cancer clinic program, the present plan and schedule of benefits to cancer clinics in New Jersey is being presented. This plan was thoroughly discussed and unanimously approved by the Advisory Committee on Cancer Control of The Medical Society of New Jersey at its

meeting on January 4, 1948. It was approved by the Board of Trustees of The Medical Society of New Jersey on January 11, 1948, and by the Board of Trustees of the American Cancer Society, New Jersey Division, Inc., on January 23, 1948.

SCHEDULE OF BENEFITS

This plan is intended to defray the basic costs of diagnostic procedures and costs of nursing and clerical services in cancer clinics throughout the state. After investigation and approval by The Medical Society of New Jersey through its Advisory Committee on Cancer Control, each clinic after approval of this committee may be eligible to receive the schedule of benefits under this plan.

The intent of these specific allowances from American Cancer Society funds is to defray clinic expenses for which the hospital receives no fee from the patient. This is not a payment for services of the medical staff or for defraying the cost of x-ray treatment.

In essence the plan provides:

1. An allowance of $2.50 for the first visit of every new indigent or medically indigent patient coming to the cancer clinic for consultation, diagnostic or therapeutic services, which are approved by The Medial Society of New Jersey and are within the scope of cancer clinic activities. This fee is allowed specifically for services of the clinic nurses plus the overhead and bookkeeping costs which the hospital clinic has to bear.

2. An allowance of 50 cents for each subsequent visit of an indigent (or "medically indigent") patient to the clinic or to the x-ray therapy section.

3. If a ward or clinic patient can pay the minimal fee, no charges will be made against the American Cancer Society.

4. In addition, if in the opinion of the attending physicians in the cancer clinic, any of the laboratory or x-ray procedures listed below are required in the study of the patient, the cancer clinic will be allowed the following schedule of credits expressed in the following units:

Complete blood count	3 units
Urine analysis (complete)	1 unit
Occult blood in feces	1 unit
a. Gastric analysis (fractional)	4 units
b. Examination of gastric or biliary drainage	4 units
Biopsy or aspiration biopsy	4 units
Papanicolaou smear	3 units
X-ray flat plate (chest)	5 units
Barium enema x-ray and fluoroscope	10 units
Complete GI series	10 units
Other single x-ray plates (of limbs, spine, etc.)	5 units
Aspiration of sternal bone marrow incl. report	3 units
Alkaline or acid phosphatase	3 units

In terms of financial benefit to the cancer clinics, each unit is temporarily assigned the value of 50 cents from American Cancer Society funds. This temporary point value may be subject to adjustment at a later date.

The sum of $520 will be appropriated to each cancer clinic, approved by the Advisory Committee on Cancer Control of The Medical Society of New Jersey. Each clinic staff will report the number of cancer patients seen at the clinic for the first time, and the number of return visits by patients. When the amount of money credited to the clinic, for clerical and nursing overhead, exceeds the basic appropriation of $520, the clinic will receive monthly checks on a current basis.

For example Clinic X received for clerical and nursing overhead the basic sum of $520 from American Cancer Society, New Jersey Division, Inc., on April 1, 1948. During April 1948, thirty new patients are seen and 100 return visits are made. Clinic X receives credit as follows:

2.50 x 30 —	75.00
0.50 x 100 —	50.00
	125.00

If the same number of new patients go through Clinic X every month during April, May, June and July, the clinic will have cumulative credit of $500 for the first four months and hence in the five months will exceed the basic allocation of $520.00. Therefore, it will be eligible for additional current financial benefit pro-rated according to the schedule.

If the clinic load is small and the sum of $520 is not attained the clinic will still retain the $520 as its annual appropriation. Thus regardless of the clinic load, approved clinics can count on a $520 minimal annual subsidy to cover clerical and nursing expenses. In other words a sum of about ten dollars per clinic session is visualized under the plan to cover the basic overhead.

An allowance of $1.50 for each follow-up visit made by the hospital social worker to the home of a cancer patient. If the hospital chooses to have the follow-up work in the field carried on by a Visiting Nurse Association representative, the same fee will be paid to the Visiting Nurse Association.

It is hoped this cancer clinic subsidy plan

will serve as encouragement to the cancer clinics, and will result in more effective early cancer case finding. It should certainly defray some of the incurred costs for which the hospital otherwise receives no financial income from a group of indigent and medically indigent persons.

It cannot be pointed out too strongly that this plan is not a "carte blanche" for every hospital in New Jersey to bill the American Cancer Society, New Jersey Division, Inc., (or any of its component county chapters) for services rendered to ward patients admitted through general out-patient department clinics or coming as in-patients directly to a medical, surgical, gynecologic or other specialty services in the hospital wards.

There is a definite need for properly subsidized voluntary hospitals. Such subsidies should be of a magnitude that only a state government can undertake adequately. Hospitals should receive subsidies for the chronically ill. The terminal cancer patient is a part and parcel of the long term patient problem. "The need for substantial aid to our New Jersey voluntary hospitals is indicated by the anticipated total deficit of these hospitals for 1947, which is $2,305,000."[2]

PERIOD OF ADJUSTMENT

This plan and schedule of benefits to cancer clinics for specific services rendered to the indigent and medically indigent patients will go into effect immediately in the case of all recognized cancer clinics applying under the new medical projects to the American Cancer Society, New Jersey Division, Inc.

In cancer clinics which are now receiving cancer funds for clerical salaries, x-ray technician or nursing services, or other financial assistance to the cancer clinic under former provisions in medical projects, submitted through county chapters of the American Cancer Society in New Jersey, all such projects will be automatically cancelled after August 31, 1948.

Clinics which wish to cancel past projects will be eligible (upon approval of the Advisory Committee on Cancer Control) for immediate application under this new plan and schedule of benefits.

EQUIPMENT SUBSIDIES

Cancer clinics may continue to apply for limited subsidies for essential diagnostic and therapeutic equipment as needed. They should, prior to making applications, carefully consider items of equipment listed in Part I Cancer Program in New Jersey[3] which has been found through experience to be adequate. Where a new clinic is being formed it has been found that they do better work and are better integrated when all equipment is concentrated in a designated room or group of rooms in the hospitals; otherwise the clinic loses its entity and equipment is rapidly dispersed. As a preliminary requirement with each new application the clinic should submit a full table of organization and all pertinent information on the number of out-patients served during the previous calendar year. Additional supporting data proving need for equipment may be required. Each application will be considered on its own merits.

For the guidance of chiefs of cancer clinics submitting requests for equipment, it is essential to understand that American Cancer Society funds will be available only for basic equipment deemed adequate in serving the purpose,—not for the more expensive "deluxe" forms of similar equipment. Where "deluxe" equipment is desired by the staff of the cancer clinic, arrangements should be made by them to have the hospital defray the difference in cost between the basic item allowed in Part I Cancer Program in New Jersey[3] and the cost of the "deluxe" article of equipment. Allowance above prices listed[3] due to general increases are taken into consideration.

FOLLOW-UP SERVICES

To project our cancer control activities into the patient's home, bedside nursing care, visits to cancer patients and the field follow-up of patients who fail to keep appointments in cancer clinics, will be continued through Visiting Nurse Associations. Existing agreements with Visiting Nurse Associations in New Jersey

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2. Schaaf, Royal A.: Message from The President, JOURNAL of The Medical Society of New Jersey, 45:480 (December, 1947).

3. JOURNAL of The Medical Society of New Jersey, 43:360 (September 1946).

To: Chairman Executive Committee
American Cancer Society
New Jersey Division, Inc.
790 Broad Street, Newark 2, New Jersey

Date.....

CERTIFIED REPORT OF FREE SERVICES TO CANCER CLINIC PATIENT

Name of Hospital..... City.....

Request of payment for specified services Rendered Free of Charge to cancer clinic patient:

Patient's Name..... Sex..... Age..... Marital Status.....

Street Address..... City..... County.....

LABORATORY SERVICES AND/OR X-RAY EXAMINATIONS RECEIVED BY ABOVE PATIENT

	(check)		(check)
Complete blood count	☐	X-ray flat plate (chest)	☐
Urine analysis (complete)	☐	Barium enema X-ray and Fluoroscope	☐
Occult blood in feces	☐	Complete GI Series	☐
Gastric analysis, fractional	☐	Other single X-ray plate (limbs, spine, etc.)	☐
Examination of gastric or biliary drainage	☐	Biopsy or aspiration biopsy	☐
Aspiration of sternal bone marrow incl. report	☐	Papanicolaou Smear	☐
Alkaline or acid phosphatase	☐		

The above patient was found by authorized hospital official to be indigent ☐ medically indigent ☐ (please indicate), and has received the specific procedures indicated by check mark. We request financial credit in accordance with schedule of benefit permitted by your Society and approved by the Medical Society of New Jersey.

.....
Signature of Social Service Worker or other authorized officer

CLINIC CHIEF'S STATEMENT

This will certify that the above Laboratory and X-ray procedures were approved and authorized by me on the above patient because of clinical findings and personal history.

..... M.D.
Chief of Clinic

List of Clinic Visits of Above Patient

	Month	*Day*	*Year*
Date of First Clinic Visit.....	.....	.....	.....
Date of each Subsequent Clinic Visit for which credit is claimed.....	.....	.....	.....
	.....	.....	.....

were carefully studied. The committees voted to adopt a uniform policy, to be instituted upon termination of the existing agreements. In the fiscal year 1948-49, contracts of the American Cancer Society, New Jersey Division, Inc., in behalf of any of the county chapters and individual Visiting Nurse Associations operating in New Jersey will be based on the prevailing rate in the county for those unable to pay any part of their costs. Credit on partial payment will be acknowledged. Furthermore, a fee of $1.50 will be allowed to hospitals for any follow-up visits to cancer patients in the field by social service personnel of the hospital, provided the cancer clinic in the hospital is approved by this committee. If the hospital chooses to utilize a Visiting Nurse Association to do the actual follow-up of patients in the home, it should notify the chairman of the executive committee county chapter American Cancer Society, New Jersey Division, Inc., of its desire and receive written authority from him.

The philosophy, which governs the adoption of a uniform rate, is based on the principle that the Cancer Society will pay only for patients who cannot pay. Hence in accepting the American Cancer Society funds, the Visiting Nurse Association is compensated for specific services previously rendered gratis.

Computation of allowances to Cancer Clinics will be made by the clerical staff of the American Cancer Society, N. J. Division, Inc.

Hospital administration and clerical staffs of Cancer clinics will not be expected to take care of computation and bookkeeping other than to fill in information on individual patients on the accompanying form.

315 West State Street, Trenton
790 Broad Street, Newark

PHYSICIANS ART ASSOCIATION ORGANIZED

Announcement has been made of the organization of a Physicians Art Association of New Jersey. Open to all members of The Medical Society of New Jersey who are interested in any form of the creative arts, the Association plans to have regular meetings to hear speakers on art topics, to plan exhibits and to institute art educational courses. Officers of the Association are Dr. Robert A. Giuliana, president, Dr. Solomon Bauch, vice-president, and Dr. Marvin Becker, secretary. Physicians interested in participating in the activities of the Association are requested to write to Dr. Marvin C. Becker, at 35 Leslie Street, Newark 8, N. J., or telephone him at ESsex 3-3223.

NEW JERSEY POLIOMYELITIS INSTITUTE

June 9—Academy of Medicine, Newark
June 10—Walt Whitman Hotel, Camden

Morning (Starting at 10 a. m.)—Present concepts of the nature of poliomyelitis and its methods of spread. Hints on the treatment of early poliomyelitis. Management of patients with bulbar and respiratory difficulties.

Afternoon (Starting at 2 p. m.)—Physical medicine and rehabilitation. Prevention of deformities. Role of the Crippled Children Commission. Role of the State Department of Health. Role of the Rehabilitation Commission. General discussion.

All physicians are welcome to attend and participate

GASTRO-INTESTINAL BLEEDING PRODUCED BY ULCERATED MECKEL'S DIVERTICULUM

Alfred J. Barbano, M.D., New Brunswick, N. J.

Meckel's diverticulum occurs in about two per cent of the population. One fourth of these cases present some symptomatology.[1] It is three times more prevalent in males than females.[2]

The symptoms run the entire gamut from inflammation through ulceration, hemorrhage, perforation and even obstruction. However, the occurrence of symptoms depends upon the presence of aberrant or heterotopic tissue in the Meckel's diverticulum. The case reported below presented an ulceration and hemorrhage due to the aberrant gastric mucosa.

Diverticula do not ordinarily produce symptoms. They are amputated in the course of an appendectomy or other abdominal surgical procedure because of the potential danger underlying such a lesion. Typical ulcer syndromes may occur in the aberrant tissue of diverticula and the entire symptom complex of peptic ulcer may be mimicked. Most common picture is one of periodic, recurrent gastro-intestinal bleeding. Perforation may occur. The diverticulum may be the site of a volvulus or even actual gangrene. As in the case reported here, acute intestinal obstruction may result from involvement of the intestine around the diverticulum. Occasionally, the symptoms closely simulate acute appendicitis; but to the chagrin of the surgeon, a normal appendix is removed necessitating a later operation unless the small intestine is investigated to rule out the possibility of a Meckel's diverticulum. Pemberton [1] states that in only ten per cent of his cases was it possible to make a diagnosis preoperatively.

The incidence of aberrant tissue varies anywhere from sixty [3] to seventy [4] per cent in those cases in which definite symptomatology is present to fifteen per cent in all diverticula. Ulceration in these lesions is probably due to the production of gastric digestive juices by the aberrant mucosa. Ordinarily the ulcer is in the intestinal mucosa adjoining the stomach. In about two per cent of diverticula, pancreatic and duodenal tissue occur.[5]

CASE REPORT

A twenty year old white girl was seen by me in consultation. Two days earlier she had a diarrhea and was given a "diarrhea mixture" which was apparently effective. Her menses started on the first day of her illness. However, the medication helped and she ate her meals without discomfort but noted persistent soft stools and a "slight menstrual flow". Two days later, attempting to go to the bathroom, she felt faint and fell to the ground. Past history was entirely negative for gastro-intestinal disease, upper respiratory infection or surgical intervention.

I found a very pale girl who appeared to be almost exsanguinated. Temperature was not elevated but pulse was soft at a rate of 120 per minute. Abdominal examination revealed no tenderness or palpable masses. Rectal examination produced a show of fresh blood on the gloved finger. Hospitalization was advised. Routine laboratory procedures indicated: hemoglobin, 30 per cent; red blood count, 2,100,000; white count, 14,500. She was immediately given 500 cubic centimeters of plasma. Typing, cross-matching and Rh determination for a compatible donor were requested. On the following day, she received a transfusion of 500 cubic centimeters of whole blood. Bleeding from the bowel persisted. She was placed on a strict ulcer regime and in addition, given 20 milligrams rutin three times daily as well as ascorbic acid 100 milligrams twice daily and protolysate every two hours. On the third day after admission, she was fed every two hours using a soft, easily assimilated diet. An additional transfusion of whole blood was given. On the following day, a blood count failed to show significant improvement in her anemia. A consultant's opinion was "duodenal ulcer (posterior wall) as the most likely diagnosis—the precipitating factor probably an upper respiratory infection."

Five days after admission, she appeared much better although a sudden pyrexia was noted. This it was felt, could be explained on the basis of the large amount of blood in the gastro-intestinal tract. Consequently, she was given small doses of milk of magnesia daily. The clinical picture continued to improve until two weeks after admission at which time, she complained bitterly of pain in the lower thorax bilaterally. Examination revealed a friction rub over the right posterior lobe. Painful

1. Pemberton, J., and Stalker, L.: *Surgery*, 3:563 (April 1938).
2. Hallendorf, L. C., and Lovelace, W. R.: *Proceedings of the Staff Meetings of the Mayo Clinic*, 22:3 (February 5, 1947).
3. Schullinger, R. N., and Stout, A. P.: *Archives of Surgery* 28:440 (March 1934).
4. Bussey, C. D.: *Histopathology of Meckel's Diverticulum*. Doctorate thesis submitted in 1938 to the Graduate School of Medicine of the University of Minnesota, Minneapolis, Minn.
5. Barbosa, D.; Dockerty, M., and Waugh, J.: *Surgery, Gynecology and Obstetrics*, 82:527 (May 1946).

areas in either leg were sought, but not found. Improvement was rapid, pyrexia declined and on the twentieth day after admission, she was discharged to the care of her family physician.

One week later she was seized with severe chest pain and an x-ray showed a small pulmonary embolus with an area of infarction. She made an uneventful recovery and was well for a month, when suddenly she began to bleed from the gastrointestinal tract and was re-admitted to the hospital. After one week of medical therapy, an exploratory laparotomy was done because of the persistent bleeding. A large Meckel's diverticulum was found in the left lower quadrant. This area had been noted on a gastro-intestinal x-ray series done earlier during her convalescence and it was felt that the location was suggestive of a diverticulum. The stomach, duodenum and entire intestinal tract, including the colon, were visualized and palpated for possible disease but nothing was found. The diverticulum was resected. It appeared to be lined almost entirely with gastric mucosa. A large vessel which had previously been ligated was seen running through the base of the ulcer. The entire ulcer area was resected. Postoperatively, the patient did well for five days, then began to show signs of intestinal obstruction. On the tenth postoperative day, she was re-opened and two points of obstruction were found—one where a loop of jejunum adhered to the suture line in the ileum and the other where a loop of ileum adhered to the cecum adjacent to the appendiceal stump. The remainder of the intestinal tract was free of adhesions and showed no evidence of inflammation. The adherent omentum was resected. On the third postoperative day she developed a toxic reaction to the procedure but the patient was ultimately discharged on the twelfth day feeling well. The incision was well healed, and her bowels moved regularly once a day thereafter. To date, the patient has done well[6] after having adhered to a rigid postoperative program and when last heard from (five months later), was feeling well enough to resume her university studies.

COMMENT

What is the proper procedure on finding an intestinal Meckel's diverticulum at operation? Some surgeons say that diverticula which are asymptomatic and have broad bases need not be removed. If the base is narrow or the lesion is symptomatic, they say it should be resected. Personally, I agree with Hallendorf and Lovelace[7] who feel that a surgeon who ordinarily removes the appendix with impunity as an incidental procedure in most abdominal operations should not hesitate to do the same thing in the case of Meckel's diverticulum. This avoids a potential source of trouble at some later date.

51 Bayard Street

BCG VACCINATION FOR TUBERCULOSIS

Vaccination with BCG does not provide complete protection against tuberculosis and, until further studies are conducted, cannot be recommended for the general population. However, since BCG does provide some degree of protection, it is recommended for members of groups constantly exposed to tuberculosis if they have a negative reaction to the tuberculin test. This is now the policy of the American Trudeau Society, Medical Section of the National Tuberculosis Association, and represents its first official statement on BCG.

BCG vaccination, developed by Calmette and Guerin from a non-virulent strain of tubercle bacilli, causes a primary tuberculosis infection. As a result of this infection, the body increases its resistance, inducing an artificial immunity. A positive reaction to the tuberculin test, indicates that a person has had a primary tuberculosis infection and his body has built up a degree of acquired immunity. Persons having a positive tuberculin test reaction probably do not benefit from vaccination with BCG.

BCG vaccine cannot be regarded as a substitute for approved public health measures to protect the public from tuberculosis.

Although studies thus far made indicate that the incidence of tuberculosis may be reduced when groups likely to develop the disease are vaccinated, the degree of protection afforded the individual is not complete and the duration of immunity is not known.

BCG vaccination is recommended for the following groups if they are subjected to more than ordinary exposure to tuberculosis: doctors, medical students, nurses; hospital and laboratory personnel whose work brings them in contact with the bacillus of tuberculosis; individuals who are unavoidably exposed to tuberculosis in the home, and patients and employees of mental hospitals, prisons and other custodial institutions among whom the incidence of tuberculosis is high.

6. Pilcher, Lewis D., M.D. (Boston): Personal communication to the author.
7. Hallendorf, L. C., and Lovelace, W. R.: See reference footnote number 2.

PROPYL THIOURACIL IN HYPERTHYROIDISM *

Walter A. Crist, M.D., Camden, N. J.

Thiouracil compounds have been used long enough to demonstrate that they are effective in the treatment of hyperthyroidism. All the investigators here cited, agree that hyperthyroidism, regardless of type, can be brought under control by these preparations. These compounds are of great value (a) in preparing patients with severe hyperthyroidism for thyroidectomy; since they abolish the need for multiple stage operations, reduce postoperative reaction, and reduce the high morbidity and mortality; (b) in long continued maintenance therapy with or without operation. Astwood [2] was one of the first to report that, after controlling hyperthyroidism for a prolonged period (six to nine months), thiouracil can be discontinued and in a large proportion of cases, a remission would be sustained.

These drugs are absorbed rapidly from the gastro-intestinal tract. A small portion (10 to 15 per cent for thiouracil) is destroyed in the gastro-intestinal tract. The secretions of the stomach, duodenum and jejunum have the capacity to break down this drug. Approximately 50 per cent is broken down in the body (essentially all tissues possessing this capacity). About a third is excreted unchanged in the urine. It is also transported through the placenta and secreted by the lactating breast in biologically active quantities. The concentration in the thyroid is many times greater than elsewhere in the body.

These drugs act by inhibiting the formation of thyroid hormone. They "block" an enzyme system concerned with the iodination of tyrosine, preparatory to the formation of thyroxine. The uptake of iodine by the thyroid gland is decreased, and the formation of thyroid hormone is prevented. Theoretically, therefore, the anterior pituitary, being unopposed, secretes a greater amount of thyroid-stimulating hormone than normal. As a result the thyroid cell becomes of a high columnar type, the thyroid follicle enlarges and its colloid is extruded, with little if any, being formed to take its place. These drugs do not effect a fundamental cure, but, merely throw a "block" across the thyroid preventing the manufacture of thyroglobulin, thus breaking the vicious cycle of hypothalamic-pituitary-thyroid relationships. If this "block" is maintained long enough, the underlying disturbance (producing the thyroid stimulation) is allowed to readjust itself. There is no refractory period with these drugs as with iodine.

That thyrotoxicosis can be effectively controlled by thiouracil, has been well established by numerous investigators [1,2] in the past four years. However, the toxicity of thiouracil made its use dangerous. The most serious of these toxic effects were leucopenia and agranulocytosis. The incidence of agranulocytosis fluctuated from 1.74 per cent to 11 per cent. The reported death rate was about 0.5 per cent. Other toxic effects (fever, rashes, arthralgia) occurred in about 20 per cent of cases.

In view of this, other goitrogenic compounds were investigated. Astwood,[2] and others, investigated some 300 compounds and found 25 of these as active as, or more active than thiouracil (2-thiouracil). Of these, propyl thiouracil (6-n-propyl thiouracil) was the most active. Substances having similar but less intense effect included thiouracil itself and other derivatives, thiourea, aniline derivatives as sulfonamides, para ameno benzoic acid, and to a much less extent, thiocyanate. Propyl thiouracil is eleven times as goitrogenic in the rat, and about five times as active in man.

Clinical reports by Astwood and Vanderlaan,[5] McGavack et al,[4] Crile,[3] others have been very favorable. Their therapeutic results with propyl thiouracil were similar to those obtained with thiouracil, while toxic effects were almost nil. In some 500 cases reviewed by Crile,[3] there was no fatality and only one case of agranulocytosis, the etiology of which is in dispute. In fact Crile,[3] stated that "propyl thiouracil has proved to have so

* Presented at the New Jersey Regional Meeting of American College of Physicians in Newark, November 7, 1947.

little toxicity that I have abandoned the practice of repeating the leucocyte count".

The rapidity of therapeutic response to propyl thiouracil appears to depend on:

1. The dosage of the drug.
2. The size and consistency of the gland.
3. Whether there has been previous iodine therapy.

A large gland as in toxic nodular goitre, or toxic adenoma, may be associated with a delayed response. Previous treatment with iodine often resulted in a latent period of several weeks or months before improvement was noted. The reason is believed to be accumulation in the gland of large stores of thyroid hormone which must be exhausted before clinical improvement can begin.

The dosage of propyl thiouracil naturally must be individualized depending on the toxicity of the thyroid and must be adjusted according to response. Dosages in excess of 200 milligrams a day are rarely indicated.

McGavack et al,[4] recommend:

Period of Treatment	Thiouracil Grams	Propyl Thiouracil Grams
0 — 7 days	0.8	0.250
0 —14	0.6	0.200
14 — control	0.4	0.200
Maintenance	0.1 to 0.3	0.025 to 0.073

After the patient has been on a maintenance dose for three or more months the dose is decreased by 25 milligrams daily each succeeding month until the patient has been maintained on 25 milligrams daily for one month; then, for an additional month, 25 milligrams every other day. If, at the end of that time, there is no recurrence of symptoms the drug is discontinued. If at any time signs of thyroid toxicity recur, the dosage is stepped up.

The incidence of lasting remissions, following withdrawal of the drug, apparently is directly proportional to the length of time the hyperthyroidism is kept under complete control. If properly controlled, the incidence of long standing remissions is high, and residual symptoms do not appear to be any more frequent than in those controlled by thyroidectomy.

In our group of twenty cases, ages varied from 27 to 64 years. Seventeen were females, three were males. Duration of symptoms varied from one month to five years. Two were cases of exophthalmic goitre and eighteen were diffuse toxic goitres.

Of these, ten were treated by propyl thiouracil alone, in accordance with the above outline of treatment. Ten were operated upon after propyl thiouracil therapy.

Of those treated medically, seven patients had no previous treatment. These included one recurrence (Case 3) after a previous subtotal thyroidectomy; six with complications (diabetes, arterial hypertension, carcinoma of the breast, hysterectomy, prostatic hypertrophy and pneumonitis). These all were under control in an average of two months. This corresponds roughly to McGavack's experience.[4] Three patients who had had previous iodine therapy were more resistant. They needed up to four months for control.

The basal rates in this "non-operated" group, prior to therapy, varied from plus 18 to plus 41; after control by propyl thiouracil, metabolism varied from plus 12 to minus 10. Five have been off their maintenance dose for five to seven months without recurrence.

Ten patients received propyl thiouracil in preparation for surgery. Of these, six were completely controlled clinically prior to operation by propyl thiouracil followed by iodine. The pathologic reports of some of these were "toxic hyperplasia with good involution". One had previously been treated by iodine, thiouracil, and x-ray, only to return six months later with metabolic rate of plus 87; after five weeks of medical treatment the rate was plus 9. Four were not completely controlled clinically prior to operation, that is, their metabolic rates were plus 28 or more. One only, of these (case 2) had had iodine for one month prior to admission. This patient was under propyl thiouracil for three and a half months. Metabolic rate fell from plus 69 to plus 37. In Case 12, after propyl thiouracil for 29 days, the metabolism decreased from plus 38 to plus 28. In Case 16, after propyl thiouracil for 38 days the rate fell from plus 52 to plus 44. The pathologic report on these three cases were all toxic hyperplasia. Undoubtedly if the drug had been continued longer, better control would have been obtained. When surgeons

become more familiar with the results of this drug, they will be more willing to delay operation until complete clinical control has been reached.

An attempt was made to correlate more definitely the pathologic picture with the preoperative preparation, with a view towards presenting a more clinching argument to the surgeons. This was disappointing, for the microscopic picture was quite variable in both the well controlled and less well controlled groups. In general, the colloid was less marked in the well controlled groups.

In one patient (case 18) after 46 days on 300 milligrams, the metabolic rate remained between plus 34 and plus 36. X-ray therapy was then administered because of the possibility of a carcinoma. After this, basal metabolism fell to plus 16. The cause of her resistance to propyl thiouracil was never determined.

In this series of twenty cases, toxic effects were noted in three. One patient (case 4) had been receiving 250 milligrams a day for eleven weeks. She developed some mental depression which vanished when we discontinued the drug, only to reappear when medication was resumed. When dosage was further reduced, however, the mental depression completely subsided. Leucopenia was noted in two patients, one of whom showed a pityriasis-rosae-like rash at the same time. In one case, the drug was not given again (the patient at the time had acute sinusitis); in the other, when the dosage was reduced, the white cell count returned to normal.

Thyroid enlargement during treatment was noticed only twice. This was not marked in either case and subsided with reduction (before discontinuance) in dosage.

Crile [3] states that one of the most important factors in determining whether the definitive treatment of hyperthyroidism should be by thyroidectomy or by antithyroid drugs is consideration of the basic physiology involved in a thyroid remission. When hyperthyroidism develops as the result of a long standing adenoma, removal of this tumor is followed by a low incidence of recurrence.

In diffuse goitre with hyperthyroidism, the entire gland is hyperfunctioning and thyroidectomy does *not* remove the underlying causes. Rather it produces a surgical block. Propyl thiouracil, similarly, does not remove the underlying causes, but produces a thyroid block *physiologically*. Results should be similar in both methods; the vicious cycle is broken in both and, in patients treated by either method who are to remain well, the abnormal stimulation of the thyroid is permitted to subside. It is hoped that this "physiologic thyroidectomy" will prove as satisfactory as surgical thyroidectomy. If remissions occur, it will be necessary to give a maintenance dose for an indefinite period or, at some later date (with the hyperthyroidism completely controlled under propyl thiouracil) to resort to thyroidectomy. It seems likely that propyl thiouracil will replace surgery in a large proportion of diffuse goitre cases with hyperthyroidism.

In adenomatous goitre, the situation is different because of the presence of one or more tumors in the thyroid. These are of cosmetic importance, tend to enlarge, may produce pressure symptoms, and are of potential danger in respect to malignancy. These, therefore, should be removed surgically. In preparing these patients for surgery, they should first be controlled completely by propyl thiouracil, followed by iodine, thus reducing the surgical risk. If contraindications to surgery are present this group can also be treated by propyl thiouracil alone.

The possible toxicity of this drug must be remembered. Since it is one of the thiouracil group it is potentially toxic. In administering it to gravid women, the therapist must not forget the possibility of cretinism in the offspring.

CONCLUSIONS

Propyl thiouracil has been found to be a safe and effective drug for the pre-operative management and medical treatment of hyperthyroidism. It removes the necessity for surgery in many cases of diffuse goitre with toxic thyroid symptoms.

The bibliography is included in the author's reprints.

405 Cooper Street

SEVERE NASAL CONGESTION FOLLOWING USE OF NAPHAZOLINE ("PRIVINE") NOSE DROPS

FOR CORRECTIONS SEE
194 V. 45 NO. 6

William G. Talmage, M.D., Succasunna, N. J.

FOR CORRECTIONS SEE
V. NO. P.

When a patient complains of a "blocked-up nose" it is so easy for the physician to issue a prescription for a powerful vasoconstrictor, instruct the patient to instill the drops and dismiss the case without further thought. As indicated by the following, this procedure may result in ultimate and stubborn vasoconstriction (precisely the opposite of the effect desired) and may even lead to a dependence on the drops which closely approaches an addiction.

A 62 year old female came to me complaining of "nose blocks up continually—have had to take drops all the time—dryness of nose requiring vaseline—unable to breathe nights without drops—persistent dry cough—shortness of breath on the least exertion, such as even walking from one room to another—nervousness—and inability to do housework".

More than a year before, a nose and throat specialist had prescribed a 0.1 per cent solution of naphazoline. The brand used was "privine hydrochloride" (NNR), a proprietary which, at that time, was available in both 0.1 per cent and 0.05 per cent solutions. The manufacturers advised in their literature that only the weaker solution should be used when prescribed for self application by the patient. In this case, it was intended for use during an acute upper respiratory infection, and the stronger (0.1 per cent) solution was prescribed. Response to these drops was so dramatic that the patient continued the drops long after original need for them should have disappeared. For more than a year now she had been using *an ounce a week*. She bought them in lots of six bottles at a time because, she said, she "had to have them to breathe". At examination I found that her eyelids were puffy. Nasal mucosa and turbinates were red and very dry but appeared unusually congested and markedly swollen. There was some postnasal drip. She also had a hypertrophic arthritis in the fingers and the dorsal spine was partly fixed from advanced arthritic changes.

Believing that the long continued use of the naphazoline* might account for the nasal congestion and nervousness, I instructed her to discontinue the nose drops. She was very apprehensive about discontinuing the naphazoline since she had depended upon it so completely for the preceding twelve months. However, she agreed to stop it and to use acetylsalicylic acid if any headache developed.

During the first four days in which the naphazoline was reduced, there was considerable improvement in the general condition of the patient. She was given ephedrine sulfate, grains 3/8 three times a day and phenobarbital, grains 1/4 with ephedrine, grains 3/8 at bed time. She used the ephedrine and phenobarbital for five days gradually reducing the number of nose drops per day. By the end of a week there was marked improvement in the appearance of the nasal mucous membrane. The feeling of apprehension and dependence upon the naphazoline* completely subsided during a period of three weeks. A month later she was able to do most of her own housework with little difficulty.

Putnam and Herwick[1] describe a condition in many respects similar to this case. Their patient had complained of nasal obstruction of about two years' duration. She had had sinusitis on at least two occasions previously. A nose and throat specialist had given her some drops (naphazoline*) and this gave her remarkable relief for four hours. Having tried other types of nose drops without relief she had returned to the naphazoline and continued its daily use for two years. The drops produced an initial vasoconstriction. The vasoconstriction was always followed by a compensatory reaction of congestion. This compensatory congestion was of much longer duration, she felt that without the drops she could not breathe through her nose.

In this connection, Putnam and Herwick[1] write: "Privine hydrochloride, a brand of naphazoline, was first described by Hild[2] in April 1941, as a preparation to reduce swelling of the

* Used in the form of "Privine hydrochloride", NNR, a Council-Accepted, proprietary brand of naphazoline.

1. Putnam, L. E., and Herwick, R. P.: *Journal of the American Medical Association*. 130:702, (March 16, 1946).
2. Hild, A. M.: *Schweizerische medizinische Wochenschrift* (Basel) 71:557, (April 26, 1941).

nasal mucosa. Hild stated that one important advantage of privine, compared with epinephrine, lies in the fact that it causes no reactive hyperemia and that it has only a relatively slight toxicity, if any. The drug appeared on the American market in October 1942. According to Fabricant and Van Alyea [3] the 0.1 per cent solution of privine hydrochloride is a nontoxic nasal vasoconstrictor which has given satisfactory use in rhinologic practice. In August 1944, Gollum [4] reported 75 cases in which symptoms of nasal congestion were aggravated or prolonged by the continued use of privine."

This recalled an experience during the World War II which served to corroborate many earlier observations. I was working in a respiratory ward of an Army general hospital where formerly it had been routine practice to prescribe 1 per cent ephedrine sulfate in normal saline solution (nose drops) for all cases of nasopharyngitis and sinusitis. Patients would tell me that they experienced relief of nasal congestion for a few minutes only following the instillation of the drops. Then they complained that their nasal passage was more congested than it had been without the drops. Ephedrine sulfate combined with drugs such as sulfathiazole, glucose, and saline, did not appreciably change the reaction. The complaints became so numerous that ephedrine was discontinued except in selected cases.

Probably most of the other vasoconstrictor drugs on the market have enjoyed variable periods of being "the only vasoconstrictor drug that will reduce swelling of the nasal mucous membrane and leave no side effects". Certainly several of them have been found unsatisfactory for other than relatively short periods of time, (rarely longer than three or four days) because of the vasodilation following the initial vasoconstriction. Sternberg [6] studied eleven different vasoconstrictors over a period of six years and concluded that the nasal discharge and obstruction observed were more probably secondary to the continued use of vasoconstrictors than to the underlying allergic condition.

Epinephrine possesses two distinct components: sympathin E and I. The first is a strong, rapidly acting vasoconstrictor, the second a weaker but more prolonged vasodilator. When the shorter vasoconstrictor phase has subsided, the vasodilation continues to be evident for several hours thereafter. Experimentally it is possible to inhibit the vasoconstrictor element of epinephrine by the previous administration of either yohimbine or ergotoxine so that the vasodilatation effect is produced immediately.

It is apparent from the studies of Kully [7] that the degree of nasal congestion is proportionate to the intensity of the initial vasoconstrictor action and to the frequency of administration and duration of use of these drugs. It seems to me reasonable to explain the vasodilatation as a secondary reaction to the intense vasoconstriction rather than as a response to allergy to the drug, or to chemical irritation of the tissues, or to definite injury to the nasal mucosa since the objective and subjective response to the discontinuance of the drugs is so dramatic.

Feinberg and Friedlander [5] have reported more than 75 patients whose nasal congestion had been aggravated or maintained by naphazoline.*

SUMMARY

1. An additional case of severe nasal congestion incident to the prolonged and frequent use of naphazoline* in the form of 0.1 per cent nose drops has been reported.

2. Discontinuance of nasal medication resulted in disappearance of the congestion within a week. The feeling of apprehension and dependence upon the drug subsided within three weeks.

3. Vasodilatation follows and is probably a compensatory reaction to the initial vasoconstriction produced by this drug.

4. I have observed similar, although less striking effects from the use of other vasoconstrictors.

3. Fabricant, N. D., and Van Alyea, O. E.: *American Journal of the Medical Sciences*, 205:122, (January, 1943).
4. Gollum, J.: *Canadian Medical Association Journal*, 51:123, (August, 1944).
5. Feinberg, S., and Friedlander, S.: *Journal of the American Medical Association*, 128:1095, (August 11, 1945).
6. Sternberg, L.: *New York State Journal of Medicine*, 44:1573, (July 15, 1944).
7. Kully, B. M.: *Journal of the American Medical Association*, 127:307, (February 10, 1945).

* Used in the form of "Privine hydrochloride", NNR, a Council-Accepted, proprietary brand of naphazoline.

EVALUATION OF IMMUNITY TO WHOOPING COUGH

George A. Maggio, M.D., Newark, N. J.

The control of whooping cough has been an academic problem involving tests such as, complement fixation, agglutination, opsonic index, mouse protective test, and controlled field trial, for assessing immunity index. The relationship between these tests and the actual protection of the individual has not been definitely determined.

Immunity index for diphtheria and scarlet fever can be measured by easily applied and interpreted skin tests. Obviously a similar skin test for whooping cough, which would be a simple office procedure and yield a reliable immunity index, is highly desirable.

Hemophilus pertussis contains at least two antigens — a so-called agglutinogen and a thermo-stable toxin, both of which can produce dermal reactions on injection. Preparations available in the past for measuring immunity index to whooping cough were not satisfactory because they contained both of the antigen factors.

Research for a specific skin testing antigen for whooping cough has continued, and within the last few years new skin testing technics with promising preliminary results have been reported.

A purified *Hemophilus pertussis* toxin was described by Stream, LaPointe and Dechne[1] which would elicit an immune response only in those who had recovered from the disease or those immunized with *Hemophilus pertussis* toxoid. Silverthorne, Fraser and Brown[2] were not able to confirm Stream's results, since they observed that the toxin did not distinguish between those who have had the disease and those presumably susceptible.

Flosdorf and Kimball[3] successfully separated the agglutinogen from the toxic components of *Hemophilus pertussis*. Flosdorf, Felton and their associates[4] have used agglutinogen to determine immunity or susceptibility to whooping cough by the response on intradermal inoculation. They established agglutinogen from phase I *Hemophilus pertussis* as the specific fraction for the pertussis skin test to differentiate between the immune and non-immune.

Reporting their experiences with agglutinogen, Sauer and Markley[5] concluded, "The agglutinogen skin test seems to be a simple method by which persons who are immune to pertussis can be readily differentiated from those non-immune." Commenting on purified pertussis agglutinogen, Tucker[6] stated, "In our opinion, it is as specific for pertussis, as the Schick test for diphtheria and the Mantoux test for tuberculosis." Boines[7] asserted that a purified agglutinogen should prove effective and satisfactory for determining the immunity index for whooping cough.

The purified agglutinogen skin test † has been used by the author in his private practice for the past two years. The test was performed on 52 children. One-tenth of a cubic centimeter of the agglutinogen was injected intradermally and readings of the skin reactions made at one-half hour and twenty-four hours after injection. Two types of dermal responses were manifested; an immediate or wheal-like reaction, and a delayed or tuberculin-like reaction.

Erythema alone was not considered in the interpretation of the test, since the determining factor in a positive immune reaction as distinguished from a negative reaction is induration.

The following procedure for assessing whooping cough immunity index with agglutinogen was followed:

1. An indurated area (with or without erythema) 20 millimeter or more in diameter at either one-half hour or twenty-four hours or both, classified as *Positive Immune,* and tabulated here as "P. I."

2. An indurated area (with or without erythema) not exceeding 20 millimeters in diameter at either one-half or twenty-four hours, but at least 10 millimeters in diameter

† Supplied by Medical Research Department, The National Drug Company, Philadelphia, Pa.

1. Stream, L. P.; LaPointe, D., and Dechne, E.: Canadian Medical Association Journal, 45:326 (October 1941).
2. Silverthorne, N.; Fraser, D., and Brown, A.: Canadian Medical Association Journal, 50:129 (February 1944).
3. Flosdorf, E. W., and Kimball, A. C.: Journal of Immunology, 39:475 (December 1940).
4. Flosdorf, E. W., and McGuiness, A. C.: American Journal of Diseases of Children, 64:43 (July 1942) *and* Flosdorf, E. W., Felton, H. M., Bondi, A. J., and McGuiness, A. C.: American Journal of the Medical Sciences, 206:422 (October 1943) *and* Felton, H. M., and Flosdorf, E. W.: Journal of Pediatrics, 22:259 (March 1943) *and* Felton, H. M., and Flosdorf, E. W.: Journal of Pediatrics, 29:677 (December 1946) *and* Felton, H. M., Smolens, L. and Mudd, S.: Journal of Pediatrics, 29:687 (December 1946).
5. Sauer, L. W., and Markley, E. D.: Journal of the American Medical Association, 131:967 (July 20, 1946).
6. Tucker, H. W.: Journal-Lancet, 67:14 (January 1947).
7. Boines, G. J.: Delaware State Medical Journal, 19:29 (February 1947).

at either or both, classified as *Weakly Positive Immune,* and tabulated here as "W.P.I."

3. No induration at either one-half hour or twenty-four hours beyond an area 10 millimeters in diameter, designated as *Negative Susceptible,* and tabulated here as "N. S."

All reactions tend to fade quickly, usually disappearing in thirty-six hours or sooner.

The fifty-two children in this study are classified in three groups as follows:

Group I: Seventeen infants, average age of 3.8 months, who had not been immunized with any *Hemophilus pertussis* antigens.

Group II: Twenty-one children, average age 19.8 months, who had been immunized six months to two years prior to the agglutinogen skin test.

Group III: Fourteen children, average age 57.7 months, who had been immunized more than two years prior to skin test.

The data are displayed in the table.

TABLE

Group	*Av. Age*	*P. I.*	*W. P. I.*	*N. S.*
I	3.8 mos.	0	0	17
II	19.8 mos	15	3	3
III	57.7 mos.	3	1	10

In group II, the average time between the last injection of the immunizing antigen and the skin test in the *Positive Immunes* was 12.5 months. In the case of the *Weakly Positive Immunes,* the elapsed time was 17.6 months, and in the *Negative Susceptibles,* it was 14.0 months.

In group III, the elapsed time between the last injection of pertussis antigen and the skin test in the *Positive Immunes* was 40 months. In the *Weakly Positive Immunes,* it was 48 months and in the *Negative Susceptibles* it was 47.4 months.

Comment

Although the series of cases is not large, certain observations are evident. The agglutinogen skin test does seem to differentiate between the immune and non-immune. The skin test lends itself readily to private practice since it is easily applied and interpretation is simple.

On the basis of the results obtained, it would seem that infants do not have a satisfactory immunity level to protect them against whooping cough. It is obvious that immunization with a satisfactory pertussis vaccine or toxoid is essential to the development of an effective immunity index. The immunity index will depreciate in time and it is suggested that a "booster" dose of pertussis vaccine or toxoid be given at two year intervals until school age; to be continued with a "booster" dose at three year intervals until high school age.

Children showing *Weakly Positive Immune* or *Negative Susceptible* reactions should be given the benefit of a second immunization course with *Hemophilus pertussis* vaccine or toxoid in order to induce a more solid immunity.

The agglutinogen skin test should be made from four to six months after the last injection of the pertussis vaccine or toxoid has been given to the child.

The agglutinogen skin test is apparently a satisfactory method of determining the immunity index in whooping cough.

419 Roseville Avenue

OPPORTUNITIES FOR ORTHOPEDISTS AND PSYCHIATRISTS

Announcement is made of a number of openings for both full-time and part-time work at Veterans Administration offices in the Newark, Trenton and Union City areas. Especially favorable opportunities are available to orthopedists and neuropsychiatrists. Salary scales (which range up to $10,200 annually) depend on the experience and training of the applicant. For further information, write to Chief Medical Officer, Veterans Administration, 20 Washington Place, Newark 2, N. J.

STATE ACTIVITIES

TRUSTEES' MEETING
MARCH 14, 1948

The regular meeting of the Board of Trustees was held at 1:00 p. m., Sunday, March 14, 1948.

Present were: Dr. Crowe, Chairman, Dr. Schaaf, Dr. Hornberger, Dr. Norton, Dr. Wood, Dr. Young, Dr. Sica, Dr. Johnsen, Dr. Lance, Dr. Hawkes, Dr. Dodd, Dr. Costello, Dr. Coleman, Dr. Allman. Also present were Dr. Davidson, Dr. Scott, Mr. Bryan and Mrs. Madden. At the request of the Chairman Dr. Wood acted as Secretary protem.

For the purpose of clarification, Dr. Johnsen moved the word "adequate" be inserted in the following resolution, approved at the January 11 meeting of the Board and subsequently distributed to all hospitals:

"That the sending of ambulatory patients to hospitals for x-rays, laboratory examinations and physical therapy treatment be discouraged where *adequate* facilities are available in private physicians' offices. Nothing in this recommendation shall be interpreted as interference with existing public health studies, mass x-rays or studies, or clinic care of the indigent."

Motion seconded and unanimously carried.

REPORT OF THE PRESIDENT

A meeting of the National Health Assembly, composed of lay and medical representatives from the entire United States, will be held May 1 to 4 in Washington, D. C. The Trustees designated the Executive Officer as the Society's representative and authorized him to attend the conference.

Our Advisory Committee on Cancer Control was designated as the official Medical Advisory Committee of the State Society to the American Cancer Society, New Jersey Division.

The Advisory Committee on Crippled Children was designated as the official Medical Advisory Committee of the State Society to the National Foundation for Crippled Children and Adults, Inc., New Jersey Chapter.

The Advisory Committee on Cardio-Vascular Diseases was designated as the official Medical Advisory Committee of the State Society to the New Jersey Heart Association.

Criticism of the Society has been made because there is no body within the organization to which complaints from lay groups can be referred. Dr. Schaaf recommended the Constitution and By-Laws be amended to authorize the Judicial Council to serve as a grievance committee, in addition to its present duties. It was voted to refer this to the Reference Committee on Constitution and By-Laws for consideration and recommendation; a report to be made at the Annual Meeting.

At present Article VI of our Constitution reads: "The Board of Trustees shall be the executive body, and shall be composed of the *Junior* Past-President, etc." Dr. Schaaf stated that this is indefinite as the Junior Past-President serves on the Board of Trustees during the first year following termination of his administrative year. With reference to the current Board of Trustees, the Junior Past-President, Dr. Scammell, died before completing his term as a member of the Board, which left a vacancy on the Board. Should interpretation of this Article be that in the event of death or incapacity of the Junior Past-President the vacancy on the Board shall not be filled, or should the Article be amended to read "the *immediate* Past-President, if living or able to serve".

Clarification of Article VI was referred to the Reference Committee on Constitution and By-Laws for study and appropriate action.

The Board of Trustees approved the nomination of Mr. William H. MacDonald, Chief, Local Health Division, State Department of Health, for honorary membership in The Medical Society of New Jersey in recognition and appreciation of his many years of assistance to and cooperation with the State Society, at the 1948 Annual Meeting.

A communication was read from the Cerebral Palsy League of Hudson County requesting recommendation of an orthopedist qualified in the care and treatment of cerebral palsy cases for appointment to their clinic. Dr. Schaaf asked that he be authorized to recommend to the League the name of an orthopedist acceptable to the Hudson County Medical Society; such recommendation to be made after consultation with the County Society. Motion seconded and unanimously carried.

In reply to a request from Assemblyman Miller for an opinion of a proposed bill to license and regulate the practice of psychology and to establish a separate "Board of Psy-

chology Examiners", Dr. Schaaf advised that the Society would oppose the establishment of a separate board, but would endorse a bill which would add a psychologist to the present Board of Medical Examiners, such member to vote only on matters pertaining to psychology.

The Board of Trustees endorsed Dr. Schaaf's reply.

Dr. Schaaf presented a letter from the Chief Medical Director, Department of Labor, which stated that, in some counties, it is difficult to secure the best ophthalmologists to testify on behalf of injured workmen, since the ophthalmologists prefer to render services to the insurance companies. This exists because insurance companies pay better fees and render prompt payment, while payment from the petitioner is contingent upon the successful outcome of the hearing. It had been suggested that some means be worked out, whereby these services would be available to the petitioner. On motion, this was referred to the Advisory Committee on Workmen's Compensation for study and recommendation at an early date.

Upon motion by Dr. Schaaf, seconded by Dr. Coleman and unanimously carried, a request that The Medical Society of New Jersey disapprove participation of the medical profession in biological and bacterial warfare, was referred to the Committee on Resolutions, to be considered during the Annual Meeting.

Chairman Crowe appointed Dr. Costello, Dr. Dodd and Dr. Sica, as a committee on the Award to the Most Distinguished General Practitioner. The Board recommended that the Committee meet within the next ten days to make a selection and decide upon the award.

Dr. Scott was authorized to attend all sessions of the House of Delegates of the A.M.A. and other A.M.A. meetings.

Dr. Schaaf moved that Mrs. Madden, Executive Assistant, be authorized to attend any national meetings of Secretaries and Editors. Motion seconded and unanimously carried.

REPORT OF THE SECRETARY

Dr. Wood reported a letter had been received from the Council on National Emergency Medical Services of the A.M.A. requesting information on any existing disaster preparations at a state level. As far as can be determined, at the present time New Jersey has no such plan.

President Schaaf was authorized to appoint a committee to study the feasibility of a state plan to meet disasters or emergencies involving the civilian population.

FINANCE AND BUDGET COMMITTEE

The Board of Trustees approved the detailed budget for 1948-49, to be presented to the House of Delegates, totalling the sum of $95,599.

Unanimous approval was also given to the recommendation to be presented to the House of Delegates that membership dues for 1949 be $23.00.

The Board approved the recommendation that "Should there be a balance from JOURNAL advertisements at the close of the administrative year, this balance be held in a Journal Reserve Account for special features to be published at the discretion of the Publication Committee".

The Board approved the recommendation that "Travel allowance for salaried employees of the Society be 8c per mile plus hotel and meals when using own car or first-class train fare plus hotel and meals."

The Board approved the recommendation that "Previous action of the Trustees that A.M.A. Delegates be allowed first-class travel by train, most direct route, and $12.00 per diem be rescinded, and the A.M.A. Delegates' allotment be on a year to year basis in accordance with the city where meetings are to be held".

REPORT OF THE EXECUTIVE OFFICER

A brief summary of the activities to date of the Executive Officer was presented for the information of the Trustees.

Mr. Bryan reported he had communicated with the Executive Director of the Crippled Children Commission regarding the non-acceptance of attending surgeons' signatures on forms requesting the purchase of prosthesis. The requirement that the signature be that of an orthopedist recognized by the Commission is a federal ruling, and must be fulfilled in order to obtain federal grants.

Mr. Bryan was then directed to determine how physicians may become eligible to sign such forms and report back at the next meeting of the Board.

A joint resolution (AJR-2) has been introduced in the Legislature creating a commission to survey conditions in voluntary hospitals, the membership to be composed of representatives of several state and private agencies. The Medical Society is not included and Mr. Bryan suggested that an attempt be made to have a member of the State Society named to the commission.

The Executive Officer was instructed to investigate the possibility of having a member of organized medicine sit on the commission.

COUNSEL TO THE SOCIETY

Dr. Schaaf reported that Mr. Albert C. Wall

of the firm of Wall, Haight, Carey and Hartpence, Jersey City, had been for many years the counsel to The Medical Society of New Jersey. Since his death, no other counsel has been designated, but the Society has been consulting Mr. Gerald F. O'Mara, formerly associated with Mr. Wall. Dr. Schaaf recommended that Mr. O'Mara be designated as counsel to The Medical Society of New Jersey.

Dr. Norton moved, seconded by Dr. Schaaf and unanimously carried, that Mr. Gerald F. O'Mara, of the firm of O'Mara, Conway and Schumann, Jersey City, be designated as official counsel to The Medical Society of New Jersey.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Dr. Dodd presented the following ten-point program of the Woman's Auxiliary for 1948-49:

1. To promote well-informed, interested county auxiliaries.
2. To issue a bulletin designed to distribute Auxiliary news and increase interest among doctors' wives.
3. To promote unity and understanding between the County Medical Societies and representatives of the Auxiliary.
4. To continue to promote an increase in membership until 100 per cent is achieved.
5. To keep alert and well-informed on medical legislation and enactments.
6. To help preserve the high standards of medical practice in the communities.
7. To acquaint every member with *Hygeia* and promote its distribution.
8. To encourage County Auxiliaries to purchase subscriptions to the A.M.A. Auxiliary Bulletin with county dues, so each member may have an added interest in the work of the national organization and the State Auxiliary.
9. To hold a second Conference Workshop early this year.
10. To study closely the health needs of each community and cooperate with the County Medical Societies to improve health conditions.

Mrs. Robert B. Walker, President-elect of the Woman's Auxiliary, outlined plans for the development of a rural health program, the objective of which is to provide general health information to rural areas, and which will be advanced through contacts with organizations existing in suburban counties. The program was contemplated as a project for the current year, but due to the concentration of all efforts on the school health program, very little has been accomplished. Continuance of the program was approved by the Auxiliary Board in October, 1947.

Dr. Allman moved as follows: "The Board of Trustees approve the Auxiliary program as presented, provided this is kept within the limits of the budget". This motion seconded and unanimously carried.

Because a commitment had already been made, Dr. Schaaf moved the Board validate the Auxiliary's offer of a $25.00 prize to the county auxiliary having the largest ratio of members serving as chairmen of lay organizations concerned with public health; such validation not to be considered a precedent nor contingent on future actions. Motion was unanimously carried.

RECOMMENDATIONS OF THE PUBLIC HEALTH COMMITTEE

WHEREAS, the American Medical Association held the first national school health conference in October, 1947, and included in its third rural health conference in February, 1948, the health and medical care problems of rural children and

WHEREAS, state and county medical societies, having child health committees and programs, have need of guidance and assistance at national levels for their child health programs by having a specific bureau of the American Medical Association responsible for children,

THEREFORE BE IT RESOLVED, that The Medical Society of New Jersey request that the House of Delegates of the American Medical Association add the words "Child Health" to the title of the present Bureau of Health Education, to read "The Bureau of Child Health and Health Education", in order that this excellent and helpful Bureau may definitely be regarded by county and state medical societies as the coordinating center in the Association for the study and evaluation of the many types of child health and medical care programs being evolved by governmental, medical, and voluntary agencies in this country.

Upon motion unanimously carried, this recommendation was referred back to the Public Health Committee for further study.

"That The Medical Society of New Jersey express its disapproval of the State Board of Health's stopping provisions for the making of cultures for gonorrhea."

Upon motion unanimously carried, the recommendation was changed as follows: "That The Medical Society of New Jersey express its regret of the discontinuance of the program of cultures for gonorrhea by the State Board of Health, and request, if possible, the program be resumed".

That the Advisory Committee on Nutrition formulate a graduate course on nutrition to be given in leading centers of the state with a nominal registration fee of $5.00 for those taking the course.

This recommendation was referred to the Committee on Post-Graduate Education.

MEDICAL PRACTICE

In regard to the listing of specialists and general practitioners in the classified section of the telephone book, and in view of the desirable features of this plan, each of the county societies be officially canvassed regarding their opinion, the Medical Practice Committee to be assigned the study of this problem as one of their projects for the coming year.

Upon motion by Dr. Costello, seconded by Dr. Schaaf and unanimously carried, the recommendation was *disapproved.*

That each year the Medical Directory of New York, New Jersey and Connecticut, is published, the State Society enter into an arrangement to buy these books in bulk and distribute them to the membership at a saving; to be done on a permanent year to year basis.

Upon motion by Dr. Allman, seconded and unanimously carried, the recommendation was *disapproved.*

That each county work out its own plan on how to handle night calls and emergency calls by the general practitioner, inasmuch as this is a local problem.

Upon motion by Dr. Sica, seconded and unanimously carried, the recommendation was approved.

That the New Jersey Delegates to the A.M.A. be instructed to take up the matter of increasing the fee for life insurance examinations to $10.00 with the House of Delegates and the Secretary of the A.M.A. for their approval; the A.M.A. to be requested to contact all insurance companies on a national basis regarding this fee increase.

Dr. Costello reported this subject had been presented by resolution from West Virginia at the January A.M.A. meeting and assigned to a reference committee for study. Since it is already under A.M.A. consideration, the Board of Trustees felt no action was required.

LEGISLATION

The following recommendation was referred to the Board of Trustees without action by the Welfare Committee:

That the Committee's action on Legislation relative to all bills listed in Bulletin No. 1 be approved; and also the "Statement from The Medical Society of New Jersey *re* cash sickness benefits," which was approved at the meeting of the Subcommittee on Legislation, February 29, be endorsed.

Dr. Schaaf moved the action of the Legislative Committee up to the point of presentation of the Statement at the public hearing, be endorsed. Motion seconded by Dr. Norton and unanimously carried.

Dr. Costello moved the sending of the "Statement" and other materials to the Legislators be approved. Motion seconded by Dr. Schaaf.

Dr. Norton spoke at length, voicing his disapproval of the action of the Legislative Committee in setting forth the attitude of The Medical Society of New Jersey in cash sickness benefits as contained in the "Statement from The Medical Society of New Jersey", and outlined his opposition.

After discussion by other members of the Board, Dr. Schaaf moved the recommendation for approval of distribution of the "Statement" and other materials to the Legislators be tabled. Motion was seconded and carried.

Dr. Schaaf moved a Committee of three be appointed to study all aspects of cash sickness benefits to clarify the philosophy of The Medical Society of New Jersey on cash sickness benefits; that this Committee convene at the earliest opportunity; that the results of the Committee's study be formulated into a compact report to be circularized to the Trustees for approval; that the Legislative Committee then be informed of the official attitude of The Medical Society of New Jersey on cash sickness benefits. Motion seconded by Dr. Johnsen and unanimously carried. Chairman Crowe appointed the following as members of the Committee: Dr. Johnsen, Chairman, Dr. Costello and Dr. Lance.

COMMITTEE ON STUDY OF MEDICAL CARE

Dr. Scott presented a detailed report of the findings of this Committee and submitted the following recommendations contained in the report for Trustee approval, prior to presentation to the House of Delegates:

a. That The Medical Society of New Jersey expand and further develop its program for graduate instruction of physicians.

b. That The Medical Society of New Jersey continue its efforts to maintain a high standard of personnel practicing in New Jersey by recommendations to the Legislature governing the requirements for a license to practice medicine in New Jersey.

Upon motion by Dr. Johnsen, seconded and unanimously carried, the recommendations were approved.

That all functions generally accepted as "public health" functions be organized on a county or other service area basis in all except Class I and Class II

counties; each area representing not less than 25,000 population. That each such area be provided with a qualified, full time health officer, sanitary engineer or qualified sanitary inspectors, public health nurses and such other qualified personnel as are necessary to meet the needs of each area, and that particular emphasis be placed upon "health instruction" as a function of public health nurses.

Upon motion by Dr. Johnsen, seconded and unanimously carried, the recommendation was approved.

1. That all qualified nurses expecting to practice within the State be required to register each year with the State Board of Nursing.
2. That the educational and public relations program now in effect to acquaint young women with the advantages of pursuing the profession of nursing as a career be expanded.
3. That since adequate nursing personnel is essential to the health and adequate medical care of the people of the state, that state money be made available for the support of the schools of nursing in the state.
4. That the program for the training of practical nurses as provided for in legislation recently enacted, be expedited.
5. That greater utilization of home service of the Public Health or Visiting Nurse by our municipalities and individual citizens be encouraged.

Upon motion by Dr. Johnsen, seconded and unanimously carried, Recommendations Nos. 2, 3, 4 and 5 (above) were approved; Recommendation No. 1 dealing with annual registration of nurses, was *disapproved* and Dr. Scott requested to delete this from his report to the House of Delegates.

Other recommendations contained in the report being of a non-controversial nature, separate action was unnecessary.

Upon motion, seconded and unanimously carried, the entire report was approved, with the deletion of Recommendation No. 1 under Nursing.

Dr. Schaaf moved, seconded by Dr. Johnsen and unanimously carried, that the report be referred to the House of Delegates with the recommendation that the Committee then be disbanded with thanks.

MEDICAL CARE OF OLD AGE ASSISTANCE CLIENTS

Dr. Scott submitted a report based upon a conference held at the office of the Division of Old Age Assistance, at which time the following principles of a proposed medical program were established:

1. An Advisory Committee in each county society should review questionable bills or advise as to other matters at the request of the Director of the County Welfare Board.
2. The patient should have free choice of physician for the first visit during any one month. Subsequent visits for the month to be authorized by County Welfare Board in accordance with a procedure approved by the county medical society.
3. A ceiling of $25 per month for medical care rendered any one individual except with approval of Medical Advisory Committee.
4. Fees: Office visits $2, house visits $3. Home visits at distance of 5 miles or more from nearest available physician $4. Services rendered multiple eligible persons during the same visit to be full fee for one person plus one-half fee for each additional eligible person, with a ceiling of $6 for any one visit.
5. Bills should be submitted to County Welfare Board monthly. The bill should not be considered valid if submitted later than the 10th day of the month following month in which service is rendered.
6. *Medical Care in Nursing Homes*—Payment to any one physician for calls in a Nursing Home during any one day should be in accordance with the fee schedule but not in excess of $6, except after consideration by Medical Advisory Committee and except where special arrangements are in effect between the Home and a physician under contract for the care of its inmates.

Upon motion by Dr. Coleman, seconded by Dr. Costello and unanimously carried, Dr. Scott's report and the principles of a proposed medical program were approved.

STATE BOARD OF CHILD WELFARE

At the Board's request, M.S.A. continued negotiations with the State Board of Child Welfare with the objective of establishing a plan for the care of their clients in Essex County similar to the City of Newark Plan. Following a study of the situation, M.S.A. decided that the operation of such a plan at an administrative cost loss, which would have to be subsidized by the Society, is not desirable, and recommends the plan proposed by the New Jersey Board of Child Welfare be placed in operation in each county; the principles of the plan to be as follows:

1. The plan to be approved by the county society.
2. To provide for free choice of physician from among a list of doctors willing to participate, to be presented by the county society, and to provide payment for physicians' services on a fee for service basis.
3. The fee schedule to be arranged with and approved by the appropriate county society in accordance with local fees up to $2 per office visit and $3 per house visit.
4. An Advisory Committee from each county society will pass upon controversial matters.

Upon motion by Dr. Schaaf, seconded by Dr. Costello and unanimously carried, the report was approved.

STATE ADVISORY COMMITTEE

In response to a request from Commissioner of Education, Dr. Wood moved President Schaaf be empowered to name two members to serve on a State Advisory Committee to consider plans for the expansion of the program for the training of practical nurses in the vocational schools of the state. Motion seconded by Dr. Coleman and unanimously carried.

President Schaaf appointed Dr. H. Wesley Jack and Dr. J. Lawrence Evans.

PUBLIC HEALTH WEEK

An acknowledgment was received from the Governor's office of our request that the week of November 8th be proclaimed "Public Health Week". The Governor is in accord with our suggestion and will be pleased to comply with the request on or shortly before November 8, 1948.

WELFARE COMMITTEE
MEETING OF MARCH 7, 1948

The meeting was opened by the chairman, Dr. Vincent P. Butler, at 2 p. m. Dr. Schaaf presented a President's report, discussing first the effect of the state governmental reorganization on the nine professional licensure boards. Under the reorganization of the state government the new Constitution provides that all agencies be consolidated into 20 or fewer departments each to be headed by a commissioner who will be a "cabinet" officer. It has been proposed that the professional boards be allocated to the Department of State. In this connection, Dr. Schaaf said:

"Professional boards in New Jersey for 60 years established and practiced integrity because they were free from political influence. Our standards are as high as those of any state in the Union. Recognizing the threat to their integrity, these boards have formed a professional council composed of representatives from each of the professional boards and each of the professional societies. They have appointed an Executive Committee of which Dr. Quigley is Acting Chairman. They plan to effect consolidation but preserve their integrity *in toto*. They propose that a department be set up, directed by a council rather than a commissioner, comprising one member from each of the boards, the Governor to designate the chairman. We have had hearings before the Committee on Reorganization and have interviewed the Governor personally. Establishment of a Department of Professional Boards is, we think, the only way in which integrity can be preserved and we can be kept free from influence. We are willing to say, under the present set-up, there would be no threat to our integrity but we do not know what will happen five years from now. An article in the papers recently called attention to political control of medical boards in many other states. This does not apply to New Jersey. We urge all of you to back our plan, since it is the only way to maintain our traditionally high standards."

Dr. Blaugrund reported that the Subcommittee on Public Health is recommending that there be a Child Health Committee on a national health level so that we can get information, if we need it, on a national set-up.

Whereas, The American Medical Association held the first National School Health Conference in October, 1947, and included in its third Rural Health Conference in February, 1948, the health and medical care problems of rural children and

Whereas state and county medical societies, having Child Health Committees and programs, have need of guidance and assistance at national levels for their child health programs by having a specific bureau of the American Medical Association responsible for children,

THEREFORE BE IT RESOLVED, that The Medical Society of New Jersey request that the House of Delegates of the American Medical Association add the words "Child Health" to the title of the present Bureau of Health Education, to read "The Bureau of Child Health and Health Education", in order that this excellent and helpful Bureau may definitely be regarded by County and State Medical Societies as the coordinating center in the Association for the study and evaluation of the many types of child health and medical care programs being evolved by governmental, medical and voluntary agencies in this country.

Upon motion by Dr. Blaugrund, seconded and unanimously carried, this resolution was adopted. Dr. Blaugrund also reported:

The Public Health Committee requests the Welfare Committee to devote an entire meeting (preferably the September meeting) to the consideration of problems which confront our Committee, interrelated with other committees, to be conducted in the form of a panel discussion, with representatives from each of the Subcommittees of the Welfare Committee taking part.

Upon motion by Dr. Blaugrund, seconded and unanimously carried, this recommendation was approved.

The Committee on Nutrition requested permission to formulate a post-graduate course on nutrition to be given in leading centers of the state, with a nominal registration fee of $5.00 for those taking the course. The request was approved.

The Committee on Venereal Disease Control requested that the law regarding over-the-counter prescribing by pharmacists be more adequately enforced for penicillin as well as sulfa drugs, because the laxity in the enforcement is becoming more noticeable.

Upon motion by Dr. Blaugrund, seconded and unanimously carried, this recommendation was referred to the Medical Practice Committee for further study.

The Committee on Venereal Disease Control asked The Medical Society of New Jersel to express disapproval of the State Board of Health's stopping provisions for the making of cultures for gonorrhea.

Dr. Blaugrund explained that cultures for gonorrhea were stopped for financial reasons. We strongly recommend the reintroduction of the program for cultures for gonorrhea. This recommendation was unanimously approved.

The Committee on Venereal Disease Control asked that the Section of Venereal Disease Control be enlarged to include dermatology and syphilology. This was referred to the Public Health Committee for further study.

Reporting for the Subcommittee on Medical Practice, Dr. Murphy said that we have been approached as to whether to invite osteopaths to come to our scientific sessions in Atlantic City at the Annual Meeting. After discussion Dr. Yaguda moved that osteopaths with full licenses be invited to attend the scientific sections of the Annual Meeting as guests.

In seconding this, Dr. Ulmer pointed out that the osteopaths realize that they should not come to the business meetings. They feel it would be a chance to bring themselves up to date on graduate study and are trying to do a good job. Our meetings are open to the public. Since they have asked for this privilege to attend our meetings it would do no harm. I think this is a "gallant move" and it would be courteous to invite them to attend.

Dr. Schaaf suggested that the words "as guests" be deleted. They may be invited to attend but the phrase "as guests" might suggest that all their expenses are to be paid.

Dr. Norton expressed opposition to the motion, stating: "Nobody in this room is more keenly aware of his responsibility to teach any member of organized medicine than I am. I recognize no responsibility to teach the osteopaths. I don't think it is the function of organized medicine to bring them up to the level of organized schools. We will be looked upon as regarding them as our professional equals. The osteopaths have recently refused to permit their schools to be inspected by the A.M.A. They have been unwilling to cooperate with organized medicine."

In answer, Dr. Schaaf said: "We are confronted with a situation with people who are fully licensed to practice medicine and who do take care of the people of the state. We have an obligation for the public welfare which makes it necessary that we do what we can to convey whatever information we have. In Essex County in 1940 an effort was made to get the A.M.A. to include fully licensed osteopaths in county and state societies. This was refused. Following that the President of this Medical Society told the House what had happened and urged we do whatever we could for these men on the ground of broad public interest. We agreed to invite these fully licensed men to attend our meetings and participate in our graduate courses. That has been the situation in Essex County since then. Many of our members have conducted special lecture courses for the fully licensed osteopaths. Most of us have addressed these groups. From the standpoint of broad public interest we should welcome the attendance of anybody for whom our program has something from which they could benefit. We must convince the general public that we are thinking not only of our group interest but that we are considering general welfare. I urge that this recommendation be approved."

Dr. Ulmer explained that in his opinion "osteopaths are fellow practitioners. It is unfair to exclude them from a scientific meeting when any lay reporter may attend."

Dr. Schaaf pointed out that a formal request had been received from the Osteopathic Society. He felt that it was unnecessary to issue any public invitation and moved that "The New Jersey Osteopathic Society be informed that our scientific meetings are open to the public; and that on that basis, they will be welcome". In this form, the motion was seconded and carried.

The Subcommittee on Medical Practice was authorized to canvass the various county societies as to their views on the listing of specialists in the classified section of the telephone directory.

With reference to medical attendance at construction jobs, the following was approved:

Insurance carriers and constructors may arrange with the doctor who is taking care of the carrier's work to set up his own medical and first-aid facilities at the job under leasing arrangements to be determined jointly by the physician, the carrier and the subcontractor, so that services be available without being in contravention of ethical and legal bans on corporate practice of medicine, it being understood that the doctor would thus operate the clinic or other first-aid or medical attendance unit.

The Subcommittee recommended that The Medical Society of New Jersey enter into an

arrangement to buy in bulk, as published, the *Medical Directory of New York, New Jersey and Connecticut* and to distribute the directory among members desiring to purchase it, the saving effected by bulk purchase being passed on to the members, the arrangement to be a permanent one, effective for each edition of this Tristate Directory. This was approved.

The Subcommittee recommended that each county work out its own plan on how to handle night calls and emergency calls by the general practitioner, as this is a local problem.

Dr. Murphy submitted the following recommendation as a member of the Welfare Committee:

That our Delegates to the American Medical Association, be instructed at the next session of the American Medical Association, to take up the matter of increasing the fee for life insurance examination to $10 and the Secretary of the American Medical Association be requested to contact all insurance companies on a national basis regarding this fee increase.

Dr. Quigley then presented the report of the Subcommittee on Legislation, which is published in full on page 251 of this issue of THE JOURNAL. With reference to the portion of the report dealing with sickness benefits, Dr. Norton made the following remarks:

"The statement from The Medical Society of New Jersey before the Senate Committee on Banking and Insurance and the Assembly Committee on Judiciary was brought to me and I was asked if it was the approved position of the Society relative to cash sickness benefits. I have no comment to make on the merits of any bill pending before Senate and Assembly. I speak only of the statement as issued. It includes the following text:

> The special interest of the medical profession of New Jersey in S-147 and A-28 stems from the fact that both these bills propose to deal, by the creation of a system or systems on cash sickness benefits, with one facet of the problem of medical care. Any part of this problem is of concern to the medical profession.
>
> In discussing this phase of the medical care problem, however, it would seem desirable first to consider what protection is already available to the employed worker and his family in this state in the event of nonoccupational sickness or accident or other surgical condition, at a cost within the means of the average worker.

"I have read from the statement which purports to be the official position of The Medical Society of New Jersey. The opening paragraph deals with the problem of medical care. It is a social problem. The problem is one of making available to the sick, monies to buy bread, meat, or any of the other necessities of life, and not only medical care. It is a social and economic problem. It concerns the impaired earning capacity of the sick, and how they are going to be paid and who is going to pay them. Some provision should be made for cash sickness benefits. We can probably direct some thought to it; but that it is concerned with medical care is most vehemently questioned. I am echoing the sentiments of the State Legislature. Here is a further quotation:

> Very few people in New Jersey suffering from severe illness or surgical conditions are today treated in their homes; they are hospitalized. The Hospital Service Plan of New Jersey, with an enrollment of well over one million, includes hundreds of thousands of employed workers and their families as beneficiaries of the Plan. At a modest subscription cost, this Plan insures the worker and his family against any and all hospital costs.
>
> Further, it is possible for the worker in industry to obtain protection against the costs of medical and surgical fees incident to the treatment of any illness or accident or surgical condition treated in hospitals, through enrollment in the Medical-Surgical Plan of New Jersey, a plan sponsored by The Medical Society of New Jersey. Incidentally, it is pertinent to observe here that our experience with medical service plans indicates quite clearly that workers in industry in this state are not interested in a plan providing protection against the cost of minor illnesses and disabilities, but they do wish protection against the more considerable medical and hospital costs of unpredictable and catastrophic illness. This Plan now has enrolled one hundred sixty thousand beneficiaries at a cost which the average worker is well able to meet, in conjunction with the protection afforded by the Hospital Service Plan.

"The question will be asked in the Legislature, I am told, about why in our voluntary plan we have but 160,000 people in this state while there are eligible for this service over 1½ million? We have failed, they tell me, to sell Medical-Surgical Plan for some reason or other and we have not reached the people we have planned to reach. The Hospital Service Plan has reached over one million and we have reached only 160,000! I know there are reasons for it; we have proceeded cautiously; we have gone as fast as we should go, etc. But, our answer of 160,000 entered for one million available in this state has been accepted as an indication of a failure on the part of The Medical Society of New Jersey to make services available to the people of New Jersey. Let me quote further:

> At hearings before the Commission on Post-War Economic Welfare on the subject, we stated the position of organized medicine as being in support of *the principle* of cash sickness benefits. Adequate clothing, food, shelter and housing, as factors in the maintenance of health, are so generally recognized as to need no underscoring; in the case of illness or disability the assurance of a basic income becomes doubly important to the breadwinner and to his family.
>
> It is our understanding that approximately fifty per cent of the workers employed in industry in this state are now covered by voluntary cash sickness benefit plans.
>
> Thus, to meet the economic need of his medical care problem, the employed worker now has access to three sound plans, operating on a voluntary cooperative basis:
>
> 1. The Hospital Service Plan of New Jersey, to relieve him of hospital costs in case of nonoccupational sickness or accident requiring hospitalization for himself or members of his family.
> 2. Through the Medical-Surgical Plan of New Jersey, the worker may be afforded protection against the cost of medical services to himself or his family for sickness requiring hospitalization. This plan also affords protection against medical fees for obstetrics and elective operations.
> 3. Voluntary cooperative plans which provide approximately fifty per cent of the working people of this state partial compensation for wage loss due to inability to work because of nonoccupational sickness or disability.
>
> We think it essential, at this point, to examine the philosophy of our approach to the economics of adequate medical care as a whole. We are of the opinion that in attempting to resolve our portion of the problem—cash sickness benefits—it would be a mistake to apply to its solution one of the very earliest devices of European state socialism: cash sickness benefits, state controlled and operated. England is a shining exemplar of the consequences of this theory.
>
> There are two opposite, contending schools of thought in this country as to how the problem of medical care

should be met. One segment of society, in which organized medicine is included, clings to the conviction that the American worker desires to assume the responsibility of meeting the regular medical needs of himself and his family, provided that there be available to him voluntary cooperative methods of assistance of the character described in the forepart of this statement.

The second school of thought, aided and abetted by persistent propaganda of various agencies of the federal government and supported by various groups, proclaims that the only way to provide adequate medical care to the people of this country is by the federalization and socialization of medicine through the device of "compulsory sickness insurance."

Members of the Legislature may question the relevance of the subject matter of this statement to the hearings on S-147 and A-28. What we have been attempting to say is entirely germane to the discussion of these bills. They deal with one phase only—a most important phase, to be sure—of the whole medical care problem. While there is, of course, an unemployment angle to this problem, we hold to the fact that, primarily, *cash sickness benefits is a medical care problem* and for that reason, is a matter of concern to the medical profession.

Perhaps the medical profession is more keenly aware of the inherent danger in the proposal to create state operated and controlled cash sickness benefit plans than some other segments of the population. Socialization and control of the medical profession has everywhere been the first step toward socialization of other professions and occupations.

Our belief is that the undeniable need for protecting the worker against the consequences of nonoccupational illness and injury can and will, *in the normal course of events*, be completely met by voluntary action. If there is need for state action, it should be limited to compelling recalcitrant employers to provide benefits by insurance or otherwise to bring about a complete coverage of all employed people at an earlier date. This was the method employed in compensation insurance and it is equally applicable here.

"That is most vehemently denied, questioned and refuted. Workmen's compensation is a socio-economic problem and *not* a medical problem. There is nothing that stipulates that he has to spend a fourth of the money he receives for medical care. He can spend it for anything he wants: coal, clothes, etc. It isn't a medical problem. We are off on the wrong tangent. Note in the above quotation, the phrase—"in the normal course of events". We want to know how long you are going to wait. We have had this Plan since 1942 and they see the tempo of "the normal course of events" is a snail's pace. Let me quote further from the statement:

Certainly, in the absence of the most compelling evidence of necessity for state action, the state should not embark upon a course that would penalize employees who already have this protection by enacting a universal tax for a state plan which would have to be paid by these employees over and above the cost of their voluntary program. Such a course of action would discourage and eventually obliterate voluntary action in this field.

The fact that there are substantial funds available in a reserve fund credited to New Jersey that could be used for this purpose is, to our minds, no good reason for action which ultimately may be regretted as contrary to good civic policy. These funds can be used for other good purposes, such as the relief of existing taxes for unemployment compensation.

"If there is need for state action in this matter it should be limited to provide benefits by insurance or otherwise bring about complete coverage within the state at an early date. We want it at an early date. We are against compulsion. We don't want a national health program. We want voluntary participation and we don't want to compel these people. I am against compelling them and I don't want them to compel me. This was the method employed in workmen's compensation. But, I don't think that I should tell them how they should run their business. Here is another little quotation from the "statement":

Governor Dewey of New York declared in a recent address: "I am profoundly convinced after eighteen years in government, that government can never do any job as well as private enterprise."

"The officers of our Subcommittee on Legislation know well from their experience that mass tuberculosis x-ray was possible because the government of Hudson County and the personnel of the Pollak Hospital went into the field and x-rayed everyone. This gives you a current living example of an excellent job. It was done by an arm of the county government. The public schools are run by the government; most social agencies are run by the government; all unemployment insurance is run by the government. There are lots of things the government can do. I have given you examples of all this. Here is another quotation from the "statement":

We in the medical profession support this philosophy, and while we are heartily in favor of the principle of extending this protection to all workers, we submit that the present voluntary tendencies to accomplish this should be encouraged and, if necessary, made universal by an enactment that would compel all employers to do for their employees what a large proportion of employers in this state have already done voluntarily.

"I offer no recommendation as to what you should do about it. I call it to your attention. I don't think it represents the attitude of organized medicine in this state as regards sickness benefit insurance and I support myself with statements of official records of The Medical Society of New Jersey. The Subcommittee on Legislation has gone far beyond its authority in attempting to commit the Society without having formal approval either from the Board of Trustees or of this Committee."

Dr. Quigley in replying to Dr. Norton's discussion reviewed the most recent supplemental report of the Subcommittee on Legislation which recounted what has been done and discussed with reference to cash sickness benefits.

"In February 1946 we submitted a statement at a hearing held in the State House which first considered this matter. Our statement at that time was in implementation of the principle of cash sickness benefits laid down by the A.M.A. House of Delegates in 1938, and reaffirmed three or four years later. In that original statement, we indicated that it was the policy of The Medical Society of New Jersey to favor such action on a voluntary basis. We mentioned that this was our general policy on the medical care problem. We opposed these two bills last year and stated our reasons; they are in the report submitted by the Committee to the House of Delegates last year which was adopted by the House of Delegates. See page 288 of the July 1947 JOURNAL. There was another hearing on March 2. Our first knowledge of it was on February 27 and over that week-end I discussed with Dr. Schaaf and the Chairman of the Committee the outline that I thought this report should take in view of our philosophy and the action of the A.M.A. This report was prepared and submitted. The philosophy enunciated here is in complete accord with the philosophy of The Medical Society of New Jersey. It *is* a socio-economic problem. All medical care

is a socio-economic problem. That the employee receive a basic minimum wage must do a great deal for his morale. This is a factor to be taken into consideration in medical care, as is the fact that his family is receiving the money that will meet the minimum needs. That seems to me to be the opinion of most of the members of The Medical Society of New Jersey. This is primarily a medical care problem. The pending bills, S-147 and A-28 are identical to the bills introduced last year, bills which we opposed and which we reported to the House of Delegates. The House approved our attitudes and actions. It seems to me that that adequately says it *is* the policy of The Medical Society of New Jersey. As for A-195 and A-200, those bills disregard all voluntary methods. They insist that all coverage of workers must be through a state operated and controlled plan.

"Compulsory sickness insurance has been the first manifestation of socialism in every country that I know of and the present situation in England is exemplary of the fallacy of that theory. As we state in the Legislative Bulletin, S-147 and A-28 are opposed by industry and labor; and these are Administration bills. Those who are in voluntary plans would be compelled to pay one-tenth of their contribution to the state operated fund in spite of the fact that they are contributors to a voluntary fund. The effect would be that within a very short time you would have no voluntary fund and no voluntary plan. There is nothing in the statement that is contrary to the philosophy of our Society. It is in harmony with our principles."

Dr. Schaaf informed the committee that, as President of the Society, he assumed responsibility for the statement. Dr. Schaaf said further.

"Dr. Quigley read this to me over the telephone. Since time was of the essence, I did not get to read a full copy—but Dr. Quigley certainly had my permission as well as that of the chairman of the Subcommittee on Legislation. I think we should settle this one way or the other. Both Dr. Norton and Dr. Quigley are right in saying that this is, in essence, a socio-economic problem."

Dr. Schaaf then moved that all parts of the report of the Subcommittee on Legislation be approved, except the paragraphs referring to cash sickness benefits; and that this be referred to the Trustees for action at their March 14 meeting. This motion was carried.

Dr. Sica read the report of the Subcommittee on Public Relations which is published on page 254 of this Journal. This report was approved. There being no further business, the committee adjourned.

Attendance roll revealed the following attendance at the meeting:

Dr. Vincent P. Butler, Chairman

Dr. Edward Guion, Atlantic County

Dr. John L. Olpp, Bergen County

Dr. Paul R. Sparks, Burlington County
Dr. R. Winfield Betts
Dr. William E. Bray

Dr. Arthur G. Pratt, Camden County
Dr. H. Wesley Jack
Dr. Edward A. Y. Schellenger

Dr. Samuel B. Hughes, Cape May County

Dr. Marcus H. Greifinger, Essex County
Dr. Harrold A. Murray
Dr. Thomas W. Harvey
Dr. Royal A. Schaaf

Dr. Wendell J. Burkett, Gloucester County
Dr. Chester I. Ulmer

Dr. J. Lawrence Evans, Hudson County

Dr. Samuel Blaugrund, Mercer County
Dr. L. Samuel Sica

Dr. John H. Rowland, Middlesex County

Dr. C. Byron Blaisdell, Monmouth County
Dr. Stanley Nichols
Dr. Louis F. Albright

Dr. Salvatore Giordano, Morris County

Dr. Joseph Jehl, Passaic County

Dr. Harry F. Suter, Salem County

Dr. James H. Spencer, Sussex County

Dr. Frederick W. Lathrop, Union County
Dr. Herschel S. Murphy
Dr. Thomas J. Walsh

Dr. Ralph M. L. Buchanan, Warren County
Dr. William H. Varney

Consultants:

Dr. Frederic J. Quigley
Mr. John J. Debus
Mr. William H. MacDonald
Mr. James E. Bryan

Guests:

Dr. J. Howard Hornberger
Dr. Yaguda
Dr. Reading
Dr. A. Hobson Davis
Mrs. Mancusi-Ungaro
Dr. Duffy
Dr. Kaufman
Miss Grace Anderson
Dr. Elizabeth M. Brackett
Dr. Hannah E. Seitzick
Miss Louise Rogers
Mrs. Ruth Lee
Dr. Weigele (for Dr. Levy)
Dr. Sol Gurshman
Dr. Rothfuss
Dr. James F. Norton
Dr. S. William Kalb
Dr. James O. Hill
Dr. Margaret M. Wurts
Dr. Blackburne
Dr. Scott

SUBCOMMITTEE ON LEGISLATION
MARCH 7, 1948

President Schaaf has given a comprehensive picture of the problem of the consolidation of the state professional boards. All the professional societies comprising the recently organized "New Jersey Council of Professions" are of the conviction that the most desirable solution would be the creation of a separate principal Department of Professional Boards. If it finally becomes necessary for the boards to be placed in one of the existing departments, there is unanimous opinion that there is no more inappropriate department for this than the Department of State. The reorganization program is the Governor's program. The Committees of the Senate and of the Assembly have completed informal hearings and have reached a decision. Their recommendations, we understand, (and these are subject to the approval of the Governor) are in accord with those originally made by the Commission on Administrative Reorganization, i. e., to place the boards in the Department of State.

There is excellent cooperation among the various societies composing the New Jersey Council of Professions and it is their intention to continue to press for a sound solution of this vital matter.

CASH SICKNESS BENEFITS

Six bills are pending proposing to deal with this subject. S-147 and A-28 are "Administration bills" and are not favored by industry or labor. A-194 and A-200 have the support of labor, with preference for A-200. A-315 and A-316 have the support of industry and carry into effect the recommendations made in the Fourth Report of the State Commission on Post-War Economic Welfare, issued April, 1946. These two bills also have the approval of your Subcommittee on Legislation.

LOCAL HEALTH DEPARTMENTS

S-148 seeks to encourage establishment of county or part-county health departments. A measure similar to this was introduced last year and had the approval of the Public Health and Legislative Subcommittees. This bill is sponsored by the New Jersey Health and Sanitary Association. Its passage would make possible the creation of health departments of a size which would provide public health administration impossible of attainment by small units of government.

INSURANCE LEGISLATION

Senate No. 105, by Mr. Barton, is a bill which would amend "An act concerning health and accident insurance" and applies to group insurance. There was some question in the minds of the Committee as to whether the measure might not affect the Society's Plan for accident and health insurance with the National Casualty Company. At the suggestion of the Committee, the Executive Secretary discussed this with the agent, Mr. William Blanksteen, and forwarded a copy of the bill. In a communication dated March 3, 1948, Mr. Blanksteen states "It was the writer's opinion as well as that of our counsel, that this bill does not affect in any way, our Physician's Special Policy as issued to the members of The Medical Society of New Jersey."

FEDERAL LEGISLATION

The prophesy made that "this was the year of decision" as to socialization of medicine appears to be in need of revision. The present federal legislative outlook makes it more likely that this may be a year of indecision. Both Marjorie Shearon and Joseph S. Lawrence, Director of the Washington office of the A.M.A., are of the opinion that neither S-1320 (the Wagner-Murray-Dingell bill) nor S-545 (the Taft-Smith-Ball-Donnell bill) are going to be reported out of committee at this session of the Congress. In a recent personal communication Dr. Lawrence also expressed the opinion that further action on S-140 (the Fulbright-Taft bill) would probably be held in abeyance pending a report of the Hoover Commission on Reorganization of the Executive Department. This bill (S-140) would create a Department of Health, Education and Security to be headed by a member of the cabinet. There would be three Undersecretaries, and under the present terms of the bill the Undersecretary of Health need not be a physician.

In Legislative Bulletin No. 18, from the Washington office of the A.M.A., we note that Senator Saltonstall of Massachusetts introduced a bill (S-2189) "to assist the states in the development and maintenance of local public-health units". On February 11, 1948, we received from the Acting Commissioner of Health, Dr. Mahaffey, a communication requesting our opinion of this bill (S-2189), The following is an extract from our letter of reply to Dr. Mahaffey, dated February 11, 1948:

"There is the same basic objection to this proposed bill as there is to S-545 (the Taft-Smith-Ball-Donnell bill), now pending in the 80th Congress. They both provide for grants-in-aid to all states regardless of the fact that the majority of the states are able to provide for these services without federal financial assistance.

"Our Society is definitely on record as not favoring grants-in-aid from the federal government, except to those states which can *demonstrate* financial need. The purpose of this bill is undoubtedly desirable: to make possible adequate and properly functioning health units throughout the country, but the application of the method proposed in the bill would impose a rigid control of public health. According to the terms of the bill 'the Surgeon-General shall by regulation prescribe criteria, the population needs, the amount of personnel of various types, the allocation of funds, administrative policy and types of health services'."

This bill, in our opinion, is one of the most dangerous measures introduced in Congress in recent years. It would place public health administration and services of the state under the absolute domination of the Surgeon-General, who it is to be remembered, serves under the Administrator of the Federal Security Agency. Perhaps the most pernicious single feature of the bill is the authority given the Surgeon-General to determine for the states *"types of health services,* including the training of personnel for local public-health work, which shall be considered basic-health services for which funds may be expended."

According to the A.M.A. bulletin of March 5 "Tentative drafts of this bill were approved by the State and Territorial Health Officers at a recent conference in Washington and a resolution supporting such legislation was adopted by the National Congress of Parents and Teachers".

This bill has been referred to the Committee on Labor and Public Welfare. We shall promptly communicate our objections of this measure to Senator H. Alexander Smith, who is Chairman of the Subcommittee on Health of this Committee and urge that this bill be not reported out of the committee.

It is recommended that action taken by the Subcommittee on Legislation relative to all bills listed in the legislative bulletin be approved; and also the statement from The Medical Society of New Jersey on cash sickness benefits, (which was approved at the meeting of the Subcommittee on Legislation February 29) be endorsed.

B. S. POLLAK, M.D., Chairman

SUBCOMMITTEE ON MEDICAL PRACTICE

MARCH 7, 1948

WORKMEN'S COMPENSATION

Dr. Harryman read a communication from the General Accident Insurance Company on medical attention at construction jobs. It was recommended the reply state that: (1) We are in accord with the idea that first aid service should be applied on the job for injured employees. (2) In order to avoid any semblance of encouraging contract practice of medicine, we recommend that the carriers, and the contractor arrange with the doctor who is taking care of the carrier's work, to set up his own facilities on the job under leasing arrangements, to be determined by the doctor, the carriers and subcontractors. In this way services can be rendered on the job without in any way going counter to the ethical and legal objection to the corporate practice of medicine. The doctor will operate the clinic and employ the nurses, etc. It was further recommended that the Welfare Committee's approval be obtained.

PHARMACEUTICAL PROBLEMS COMMITTEE

Dr. Ulmer read a letter from the Joint Committee on Professional Relations on the new trend among physicians to delegate unwarranted professional responsibilities to office assistants. After considerable discussion Dr. Ulmer moved that this matter be carried over for an early and sincere study next year by this Committee.

TELEPHONE LISTING OF SPECIALISTS

Dr. Murphy reported that the listing of specialists in the classified section of telephone directories is not against the ethics of the A.M.A. but that it is a local and state matter. It was recommended that in view of the desirable features of listing specialists and general practitioners in the classified section of telephone directories, each of the county societies be officially canvassed regarding their opinion; the Medical Practice Committee to be assigned the study of the various angles of the problem as one of its projects for the

coming year. It was regularly moved that this recommendation be presented to the Welfare Committee.

ATTENDANCE OF OSTEOPATHIC PHYSICIANS AT ANNUAL MEETINGS

Dr. Murphy presented a request from the fully licensed osteopaths for permission to attend scientific sessions at the annual meeting.

After considerable discussion it was moved that osteopaths with a full license be invited to attend the scientific sessions of the annual meeting as guests. Motion was unanimously carried. (For action on this, see Welfare Committee, page 247, this JOURNAL.)

PROBLEM OF NIGHT CALLS

Dr. Murphy presented a criticism of doctors who have not been making night calls, which had been discussed in a recent A.M.A. Secretary's News Letter. It was the consensus of opinion that this is a problem for the county societies; each should be allowed to initiate the program it wants to follow.

TRI-STATE DIRECTORY

Dr. Yaguda recommended that each year the Tri-state Medical Directory is published, the Medical Society arrange to buy the Directories in bulk and distribute them to our members at a saving; this to be done on a permanent year-to-year basis. Motion was unanimously passed.

SCHOOL PHYSICIANS

The subject of the school physician, his appointment and seniority, was discussed. It was the opinion of the committee that this should be handled on a county basis.

ANNUAL REPORTS

Annual Reports of the Advisory Committees were presented and approved.

H. S. MURPHY, M.D., Chairman

SUBCOMMITTEE ON PUBLIC HEALTH

MARCH 7, 1948

HONORARY MEMBER—1948 ANNUAL MEETING

It was moved, seconded and unanimously carried that Mr. William H. MacDonald of the New Jersey State Department of Health, be nominated for honorary membership in The Medical Society of New Jersey, in recognition and appreciation of his many years of assistance to and cooperation with the State Society.

ADULT DISEASE CONTROL

At the request of the Motor Vehicle Department, the committee studied the physical examination forms used in that Department. The following report of the results of the study was accepted:

(1) The form for the re-examination of drivers over 65 years of age, and the form for the examination of drivers supposed to be intoxicated, are considered adequate and complete.

(2) The Romberg test is not a standard test for intoxication.

(3) These examinations should be made by physicians in various communities designated by the Department of Motor Vehicles. The family physician should not be embarrassed by having to make these examinations of his own patients.

CHILD HEALTH

The following recommendation was unanimously approved:

Recommendation to the House of Delegates, Medical Society of New Jersey, from the Child Health Committee. The Child Health Committee recommends that the following resolution be adopted by the House of Delegates of The Medical Society of New Jersey and presented by our Delegates to the House of Delegates of the American Medical Association in June, 1948.

RESOLUTION

WHEREAS, the American Medical Association held the first National School Health Conference in October, 1947, and included in its third Rural Health Conference in February, 1948, the health and medical care problems of rural children and

WHEREAS, State and County Medical Societies, having Child Health Committees and programs, have need of guidance and assistance at national levels for their child health programs by having a specific bureau of the American Medical Association responsible for children,

THEREFORE BE IT RESOLVED, that The Medical Society of New Jersey request that the House of Delegates of the American Medical Association add the words "Child Health" to the title of the present Bureau of Health Education, to read "The Bureau of Child Health and Health Education", in order that this excellent and helpful Bureau may definitely be regarded by County and State Medical Socleties as the coordinating center in the Association for the study and evaluation of the many types of child health and medical care programs being evolved by governmental, medical, and voluntary agencies in this country.

NEWARK SURVEY OF SCHOOL HEALTH PROBLEM

Dr. Harrold A. Murray reported strong opposition from physicians in the attempt to form county councils for the improvement of school health, the chief cause of dissention being antagonism between school physicians and general practitioners. A recent survey of physicians of all Essex municipalities reveals that there is a certain amount of cooperation between school physicians and general practitioners, and a certain number of referrals; but in the majority of cases, parents are informed of their children's need of medical attention by a note from the school nurse.

After prolonged discussion regarding the many difficulties which arise when attempts are made to institute health programs on a local level, it was concluded the scope of these problems reached far beyond the Public Health Committee and involved all other subcommittees.

As a step toward solving these difficulties, Dr. Murray moved that the Public Health Committee request the Welfare Committee to devote an entire meeting (preferably in September) to the consideration of problems confronting the Public Health Committee, interrelated with other committees; to be conducted in the form of a panel discussion, with representatives from each of the subcommittees taking part. Motion was unanimously carried.

NUTRITION COMMITTEE

Approval was granted to the Committee's request for permission to formulate a postgraduate course on nutrition to be given in leading centers of the state, with a nominal registration fee of $5.00 for those taking the course.

CRIPPLED CHILDREN COMMITTEE

The annual report, as presented by Dr. Reading, Chairman, was approved. One of the main concerns of the Committee has been the many voluntary agencies interested in crippled children, which have overlapping functions and were out-of-hand as far as medical supervision is concerned. The Committee has outlined a long range program of cooperation with these agencies, and as a result of joint meetings, a better understanding has been reached.

VENEREAL DISEASE CONTROL

The following recommendations were approved:

1. The Committee on Venereal Disease Control requests the law regarding over-the-counter prescribing by pharmacists be more adequately enforced for penicillin as well as sulfa drugs, because the laxity in the enforcement is becoming more noticeable.

2. The Committee on Venereal Disease Control recommends The Medical Society of New Jersey express its disapproval of the State Board of Health's stopping provisions for the making of cultures for gonorrhea.

3. The Committee on Venereal Disease Control requests the Section on Venereal Disease Control be enlarged to include dermatology and syphilology.

SAMUEL BLAUGRUND, M.D.,
Chairman

SUBCOMMITTEE ON PUBLIC RELATIONS

MARCH 7, 1948

The Subcommittee on Public Relations is developing a rounded plan for providing public information about the society's programs, and for furnishing health educational services through the radio, newspapers, and schools.

Within the Society, we have improved our methods of keeping the membership informed about our policies and activities. By now, the Executive Officer has visited all of the twenty-one county societies. In every case, he has offered a brief talk on the current affairs of the Society with particular reference to our Public Relations activities and the part that the county societies can play in this work.

Another improvement in our coordination with the individual members and the county societies has been the publication of our monthly News-Letter, which is sent to the entire membership. This has received favorable comment from members in every part of the state.

The Committee has reviewed copy for the first *Quarterly News-Letter* to be sent to two hundred voluntary agencies interested in health and medical affairs. This periodical, about half the length of our Membership News-Letter, is designed to interpret currently and authoritatively the viewpoint of The Medical Society of New Jersey on matters of general civic interest. Whenever it is desirable to do so, this can be used to stimulate support from our lay friends for projects or policies that require and deserve public support.

Transcribed radio programs provided by the American Medical Association are being regu-

larly broadcast by the nine principal radio outlets in the state. We have been greatly aided by the state and county components of the Woman's Auxiliary in making arrangements with the broadcasting stations.

The Trustees recently approved another radio program which originates in Providence, Rhode Island, under the title "Doctor's Orders". This fifteen-minute program consists in part of a dramatic presentation with musical background. The final section of each broadcast is a brief interview with a local doctor appearing personally at each radio outlet. He discusses the medical topic of the program's dramatic presentation. These programs were developed by the Council of the New England State Medical Societies and arrangements are being made to have them presented over several stations in New Jersey with the endorsement of The Medical Society of New Jersey. The arrangements include provision for commercial sponsorship in each area. The identity of the commercial sponsor, as well as all announcements on his behalf, are subject to the specific approval of The Medical Society.

Our weekly health educational release to newspapers, under the title *Health Hints,* has now been placed on a permanent basis under arrangements that permit these releases to be distributed under the joint sponsorship of the State and county societies in each area. With the help of the county societies, a special effort will be made this year to stimulate a wider use of this service by newspapers. This material is also regularly sent to industrial house organs throughout the state.

We are distributing another health news service prepared by the Society, known as *Junior Health Hints.* These are sent each week to more than 1600 classroom teachers and health education instructors throughout the state. This service is the result of direct requests for this material from supervising principals and teachers. It provides an ideal medium for our committees on various health and medical topics to present educational material to the schools.

Special newspaper releases have been sent out from time to time on matters of current interest whenever some special event provided occasion for a news story. In this connection, the implementation of our school health program with the effective aid of the Woman's Auxiliary, has been the subject of more favorable newspaper notice and editorial comment than any other single activity within the memory of your Committee.

The Subcommittee on Public Relations proposes to hold an all-day public relations conference on Sunday, May 16. Each county society will be requested to send its president, its president-elect, the chairmen and members of its public relations and public health committees, together with their counterparts in the county Woman's Auxiliaries.

We plan to arrange with the Public Health Committee to devote the morning session to plans and suggestions for organizing Public Health Week programs in the various counties and municipalities. The date for this observance has been set for November 8 to 12. It is, of course, primarily a public health project, but it has public relations aspects, and we want to give every assistance to the Public Health Committee in the furtherance of this project.

The afternoon session at our Public Relations Conference on May 16 will be devoted to various other public relations services of the society, with particular attention to ways of coordinating these activities with the county societies. Many of the activities of the State Society in public relations, public education, public health, and in the promotion of voluntary insurance plans, are only paper programs until they are translated into reality on a county level and in the individual communities, by the county societies. Therefore, there must be the utmost cooperation between the county and the State Society. The objective of this Public Relations Conference, which we hope may become an annual affair, will be to develop this cooperation so that our work next season may be even more effective that it has been this year.

L. S. Sica, M.D., Chairman

MEMO FOR PENNSYLVANIA ALUMNI

On Saturday, June 12, 1948, the Medical Alumni Society of the University of Pennsylvania will hold clinics from 9:30 a. m. to 12 noon, at the University Hospital and a luncheon at 1 p. m. at the Penn Sheraton Hotel. Dean Starr will review the year's events and plans for the Medical School's future. All Pennsylvania Medical Alumni are welcome.

HOSPITAL AND HEALTH CENTER FOR HUNTERDON COUNTY

Announcement has been made of plans for the establishment in Hunterdon County of a unique hospital-health center combination, under the auspices of a grade A eastern medical school. It is expected that one third of the cost will come from federal funds under the Hill-Burton act, as Hunterdon has the state's number 1 priority for this. A one-hundred bed hospital is contemplated, and the building will also house the usual health center facilities and provide a nurses' training school. The maintenance cost it is estimated, will not materially exceed the sums now paid by Hunterdon County residents for hospitalization outside the county. Most of the capital funds will be raised locally. The Hunterdon County Medical Society has voted "to cooperate in every way if the hospital is to be run on a high plane of medical competency". This high standard seems assured by the agreement of a university medical school to furnish supervisory and consultative service.

Prime mover behind the project is the Hunterdon County Board of Agriculture. This body voted in March 1946, to institute formal investigation of the need for a hospital in Hunterdon. The preliminary study was made by a committee of this Board headed by Mr. L. B. Westcott of Clinton, and after presentation of the preliminary findings to the citizens of Hunterdon County, Dr. E. H. Corwin (research secretary of the New York Academy of Medicine) was engaged to conduct a more detailed survey. Dr. Corwin gave a provisional report to the Hunterdon County Medical Society in November 1947, and a more detailed report to a group of representative citizens of the county in January 1948. This revealed that—

Hunterdon is the only county in New Jersey without a general hospital.
There are practically no health protective services in the county.
School health services are inadequate.
There is not a single medical or surgical specialist in Hunterdon County (outside of the staff at Glen Gardner).
There is no organized blood transfusion facility.
There are no public diagnostic or x-ray laboratories.
There are no cancer clinics in the county.
The county's death rate was 20 per cent higher than for the state as a whole (12.1 compared with 10.7).
That 85 per cent of the medical practitioners in Hunterdon had no hospital appointments.
There was no nurses' registry.
There were only nine public health nurses instead of the 19 required by its population.
There were no facilities for contagious disease patients.
There were no public immunization services.
That 8 per cent of the residents of Hunterdon County were hospitalized every year—all of them, of course, being obliged to travel to institutions outside the county.
That 17 per cent of the babies born to Hunterdon County mothers were delivered at home.
That the State Department of Institutions and Agencies would certify Hunterdon for top priority for hospital building funds under the Hill-Burton act.

With the approval of the county medical society and the support of most of the citizens of the county, the Board of Agriculture has made visible progress in implementing the project. Steps have already been undertaken to incorporate a Founders' Committee and a vigorous campaign is planned for the summer of 1948. The people of Hunterdon are frankly aiming at "the best rural medical service in the country".

STATUS OF EMIC PROGRAM

Congress directed the liquidation of the Emergency, Maternity and Infant Care Program and it is anticipated that the program will be discontinued entirely about April 1949. All cases already authorized for medical and hospital care will be paid for and completed.

For a woman to be eligible for care she must have been both pregnant and the wife of a serviceman in one of the four lower pay grades on or before June 30, 1947. Infant care will be authorized only if the mother or infant was eligible for care on or before June 30, 1947. Physicians in doubt as to the eligibility of an infant, should list the facts and write to the Division of Maternal and Child Health, Room 430 at 143 East State Street, Trenton 8, New Jersey.

JULIUS LEVY, M.D., Chief,
Division of Maternal and Child Health.

TO N. J. MEDICAL AUTHORS

We propose to revive the column entitled "With New Jersey Medical Authors". Our role will be primarily that of a central clearing agency. This column will, as in the past, attempt to list all published writings—both book and journal articles—of the medical profession in New Jersey. If such a compilation is to serve a useful purpose, full bibliographic details are desirable with respect to the output of any contributor to the medical literature. Therefore, may we here ask for the cooperation of the author in supplying us with the following information on items published:

(1) If a book, please give place of publication, publisher, date and complete title of work.

(2) If a periodical article, give us the title of the paper or article, the name of the periodical in which the article appeared or is to appear, in short, the month, date, volume and page number.

The column will, in all likelihood, be published four times yearly. For this initial compilation may we ask that all published contributions subsequent to October 1, 1947, be included when reporting items for inclusion in the initial list. Send or phone this information (MArket 3-2688) to the undersigned.

HARROLD M. GOETTEL, Librarian
Academy of Medicine
91 Lincoln Park
Newark 5, N. J.

CHEST CLINIC SERVICE

In response to numerous inquiries, THE JOURNAL here publishes a directory of tuberculosis and chest clinics. Write or call the place concerned for more details, or communicate with Dr. W. A. Doppler, N. J. Tuberculosis League, 15 East Kinney Street, Newark 2.

Atlantic County

ATLANTIC CITY: Hospital, 1101 Baltic Avenue
HAMMONTON: Public Health Center, 11 North Egg Harbor Road
MAYS LANDING: Court House
PLEASANTVILLE: Pine Rest Clinic

Bergen County

CLIFFSIDE PARK: Board of Health
ENGLEWOOD: Board of Health
GARFIELD: Board of Health
HACKENSACK: 225 State Street
RIDGEWOOD: Bergen Pines

Burlington County

BURLINGTON: City Hall Annex

Camden County

CAMDEN: Cooper Hospital(1)
CAMDEN: City Hall Room 101

Cape May County

CAPE MAY COURT HOUSE

Cumberland County

BRIDGETON: Hospital
MILLVILLE: Hospital
VINELAND: Newcomb Hospital

Essex County

BELLEVILLE: Isolation Hospital
BLOOMFIELD: 82 Broad Street
CALDWELL: County Sanatorium(2)
EAST ORANGE: General Hospital Clinic(3)
IRVINGTON: Clinic of General Hospital
MONTCLAIR: 65 Chestnut Street
NEWARK: See list below
ORANGE: St. Mary's Hospital(3)
ORANGE: Orange Memorial(3)

City of Newark

Beth Israel Hospital
Board of Health (94 William Street)(3)
Cutler Street at Sixth Avenue
115 Ferry Street
106 West Street
Pennington Court
Seth Boyden Court
Babies Hospital

Gloucester County

PITMAN: Borough Hall
WOODBURY: Underwood Hospital

Hudson County

BAYONNE: Hospital
HOBOKEN: 309 Clinton Street
JERSEY CITY: 100 Clifton Place
KEARNY: 41 Kearny Avenue
UNION CITY: 3901 Park Avenue

Hunterdon County

GLEN GARDNER: Sanatorium

Mercer County

PRINCETON: Hospital
TRENTON: Room 16, Municipal Building
TRENTON: 148 East Front Street
TRENTON: Donnelly Memorial, Tuberculosis Unit(3)

Middlesex County

CARTERET: Board of Health
METUCHEN: Roosevelt Hospital
NEW BRUNSWICK: St. Peter's Hospital
PERTH AMBOY: 277 Bertrand Avenue
SOUTH RIVER: Borough Hall

Monmouth County

ALLENTOWN: Fire House
ALLENWOOD: Hospital(3)
ASBURY PARK: 913 Sewall Avenue
ASBURY PARK: 108 Atkins Avenue
FREEHOLD: Health Center
KEANSBURG: Health Center
KEYPORT: Health Center
LONG BRANCH: Garfield Court
MATAWAN: Health Center
MIDDLETOWN: Health Center
NEPTUNE: Fitkin Hospital
RED BANK: Borough Hall

Morris County

SHONGUM MOUNTAIN SANATORIUM

Ocean County

LAKEWOOD: Kimball Hospital

Passaic County

CLIFTON: Board of Health
PASSAIC: Department of Health
PATERSON: Board of Health
POMPTON LAKES: Municipal Building

Salem County

SALEM: Hospital

Somerset County

SOMERVILLE: Somerset Hospital(3)
SOMERVILLE: 32 North Bridge Street

Sussex County

NEWTON: County Service Building

Union County

ELIZABETH: St. Elizabeth Hospital
PLAINFIELD: Muhlenberg Hospital
SCOTCH PLAINS: Bonnie Burn

Warren County

PHILLIPSBURG: Hospital

(1) Physicians' referrals only.
(2) Appointments made through Red Cross, 14 Park Avenue, Caldwell.
(3) Pneumothorax treatments available.

NEW JERSEY ALLERGY SOCIETY

The organizational meeting of the New Jersey Allergy Society was held on February 18, 1948, in Newark. Thirty-three charter members attended, representing all parts of the state.

Officers elected were: president, Dr. Nathan Schaffer, East Orange; vice-president, Dr. Ralph Alford, Montclair; secretary, Dr. William Greifinger, Newark; treasurer, Dr. Frank Rosen, Newark. Executive committee members: Dr. Louis Byck, Newark; Dr. Eugene Luippold, Boonton; Dr. William Nevius, East Orange; Dr. Joseph Skwirsky, Newark.

Membership is open to physicians interested in the practice of allergy who are members of their county medical societies. Applications may be addressed to Dr. William Greifinger, Secretary, 31 Lincoln Park, Newark.

The first scientific meeting of the Society was held at the Academy of Medicine in Newark on May 12. The program consisted of a panel discussion of hay fever.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

Ask each patient you admit to a hospital: "Are you enrolled in Medical-Surgical Plan of New Jersey?"

When a patient, not entitled to full service benefits in accordance with the Schedule of Benefits of the Plan, requests the services of a Participating Physician, the patient and physician should agree in advance on the amount of the total fee.

The Board of Trustees of the Plan believes that the patient is entitled to know the cost of a physician's service at the time the service is requested.

NORMAN M. SCOTT, M.D.

"TOTAL CARE" FOR ORTHOPEDIC PATIENTS

The concept of total care for orthopedic patients was discussed by Dr. Howard A. Rusk at a conference on "Education of Hospitalized Children" at Atlantic City, February 26, sponsored by the National Foundation for Infantile Paralysis. Drawing on his experiences in the Air Force and at the Rehabilitation Center in Bellevue Hospital, Dr. Rusk said that the patient, not the disease must be treated. "You can't put a patient's mind in a cast," he said, adding that the educator must be a prominent member of the professional team caring for him.

Two hundred and nineteen representatives from 32 states attended the conference to promote better schooling for child-patients in hospitals and convalescent centers. They included teachers in hospital schools, hospital and school administrators, physicians, nurses, psychologists, physical and occupational therapists and social workers.

Team-work on the part of the professional staff (hospital administrators, doctors, nurses, therapists, and teachers) was stressed by Dr. Waldo E. Nelson, Professor of Pediatrics, Temple University, who recommended frequent case conferences of the whole group built around the child himself. In the ideal institution, he said, everyone would be an educator in preparing the child to step into a mature role and face life. To this end, schedules must be adjusted to the child and not to the convenience of the hospital staff.

The conference group agreed that the handicapped child who depends more on mental than physical skills needs more than just "textbook learning", and that better education can be provided by all-day planned instruction and group participation than by an hour or so of daily tutoring.

Other recommendations for improvement of current educational practices in hospitals were: establishment of a pre-school program with dynamic recreation as opposed to passive entertainment; provision for visual aids and space for group teaching and discussion; introduction of parents to the hospital planning for better understanding of their own child's needs; more opportunity for special training of hospital teachers; a widespread public information program to create interest in community groups in attaining education goals and more generous financing.

SPECIAL LECTURES AT LYONS

Announcement is made of the following lectures at the Veterans Hospital in Lyons, N. J. All of these are open to the medical profession. Lyons is centrally located between Bernardsville and Plainfield and is accessible by good roads from all parts of the state. Lectures are held in the Nurses' Classroom. Ample time will be allowed for discussion.

Date	*Hour*	*Speaker*	*Topic*
May 10 (Monday)	6:00 P. M.	J. H. Van Ophuisjen	Psychotherapy
May 13 (Thursday)	1:00 P. M.	Mortimer Ostow	Electro-Encephalography
May 13 (Thursday)	3:30 P. M.	Roland Roecker	Electro-Encephalography
May 24 (Monday)	6:00 P. M.	J. H. Van Ophuisjen	Psychotherapy
May 25 (Tuesday)	8:30 P. M.	The Staff	Neurologic Clinic
May 27 (Thursday)	1:00 P. M.	Mortimer Ostow	Electro-Encephalography
May 27 (Thursday)	3:30 P. M.	Roland Roecker	Electro-Encephalography
May 29 (Saturday)	9:00 A. M.	Henri Sanson	Religion and Psychiatry
June 5 (Saturday)	9:00 A. M.	Leo P. Crespi	Religion and Psychiatry
June 7 (Monday)	6:00 P. M.	J. H. Ophuisjen	Psychotherapy
June 14 (Monday)	6:00 P. M.	J. H. Ophuisjen	Psychotherapy

SUPPLEMENTARY LIST No. 1
to the
1948 OFFICIAL LIST OF MEMBERS

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Anderson, Ethelyn J., 195 Euclid av., Ridgef'd Pk.(2)
Barbarito, William N., 135 Bentley av., Jersey C. (9)
Barrett, James W., 252 No. Arlington av., E. Or. (7)
Beyer, William, 612 Undercliff av., Edgewater (2)
Black, Leroy W., 33 W. Passaic av., Rutherford (2)
Blanchard, Kenneth, 144 Harrison st., E. Orange(7)
Blaustein, Maurice L., 859 S. 13th st., Newark (7)
Borow, Maurice, Bound Brook Hosp., Bd. Brook(18)
Braun, David C., Newton (19)
Brown, Edward V., 9 Park av., Caldwell (7)
Brown, J. Edward, 2611 Center st., Mechantville (4)
Burnett, Hayes J., 1 Hawthorne pl., Montclair (7)
Caldwell, Julius A., 45 S. Mountain av., Montclair(7)
Choffy, Sylvester A., 202 Bergen av., Jersey City (9)
Christensen, Alex, Lebanon (10)
Ciccone, Roy R., 57 Passaic av., Passaic (16)
Cook, Martin J., 151 Livingston av., N. Brunsw'k(12)
Cordasco, Peter, 517 Roseville av., Newark (7)
Crandell, Archie, N. J. State Hosp., Greystone P.(14)
Cucinella, Anthony B., 361 Lafayette st., Newark(7)
Daron, Simeon, 31 Lincoln Park, Newark (7)
David, Leopold S., 326 Cooper st., Camden (4)
Davies, George W., 35 Fairview av., Verona (7)
Davis, William J., 144 Harrison st., East Orange (7)
Decker, John G., 143 Terrace av., Hasbrouck Hts.(2)
DeGregorio, Peter J., 56 Prospect st., Madison (14)
DeHart, George K., 132 Sunset av., Verona (7)
DeLuca, Louis, 323 E. Ridgewood av., Ridgewood(2)
Dewis, Edwin G., 21 Westra st., Interlaken (7)
Dirr, John P., 785 Main av., Clifton (16)
Egolf, Donald C., 15 Washington st., Newark (7)
Farmer, Vincent, 430 Union st., Hackensack (2)
Perguson, John A., Monmouth Mem. Hosp., L. B.(13)
Fissell, George M., 140 Roseville av., Newark (7)
Forte, F. Chester, 374 Park st., Hackensack (2)
Fortuin, Floyd, 434 Park av., Paterson (16)
Friedlander, Kurt F., 25 So. Munn av., E. Orange(7)
Froelich, Jerome J., 74 Ingraham pl., Newark (7)
Garibaldi Louis J., 1018 Hudson st., Hoboken (9)
Goldowsky, Ira, 23 Warner av., Jersey City (9)
Grunt, Louis, 80 Millington av., Newark (7)
Halnan, John J., Jr., 631 Madison av. Paterson (16)
Halpern, Melvin M., 493 Central av., Newark (7)
Hand F. Gordon, 119 Irvington av., So. Orange (7)
Higgins, Thomas F., 224 Monmouth rd., Elizab'h(20)
Husik, Franklin B., 101 S. Main st., Glassboro (8)
Janifer, Clarence S., 208 Parker st., Newark (7)
Jukofsky, Isidore D., 335 Main st., Ridgefield Pk.(2)
Kaplan, S. Bernard, 31 Lincoln Park, Newark (7)
Kaycoff, Aaron J., 1063 North av., Elizabeth (20)
Kelly, J. Paul, 30 Ridgedale av., Morristown (14)
Kissinger, Donald J., 315 Engle st., Teaneck (2)
Lamy, Anthony, 560 Newark av., Elizabeth (20)
Largay, Arthur O., 937 Avenue C, Bayonne (9)
Lease, Henry J., 111 74th st., North Bergen (9)
Lewis, Thomas K., 130 N. Broadway, Camden (4)
Lichtenberg, Walter, 309 Kindekam'k rd.,W'tw'd(2)
Lippincott, Lansing Y., 939 Park av., Plainfield (20)
Lorenze, Edward, 196 Prospect st., East Orange (7)
Maddren, Russell F., 372 Union st., Hackensack (2)
Manfro, Gerard J., 35 Newark st., Newark (7)
McLaughlin, Thomas F., 19 Durham st.,Met'ch'n(12)
Merrick, Evelyn Z., 142 Clinton av., Newark (7)
Messinger, Samuel J., 31 Roosevelt av., Carteret (12)
Morrow, Joseph R., 45 N. Broad st., Ridgewood (2)
Nataro, Joseph, 172 Littleton av., Newark (7)
Nelson, Harry, Lupton av., Woodbury (8)
Perelman, Julius S., 94 Shanley av., Newark (7)
Persico, Anthony J., Col. & Railr'd av.,Harr'gt'nP.(2)
Ravitz, Israel, 4 Newman av., Verona (7)
Riley, Philetus H., 181 South st., Morristown (14)
Rosamilia, Ralph E., 480 N. 7th st., Newark (7)
Ross, Bernard, 30 E. Passaic st., Maywood (2)
Rothenberg, Friedrich, 395 Ellison st., Paterson (16)
Rowen, Manuel J., 463 E. Jersey st., Elizabeth (20)
Russell, David L., 690 Bergen av., Jersey City (9)
Salmon, George G., Jr., 243 S. Harrison st., E. O. (7)
Salva, Edo J., 17 West Central Blvd., Palisades P.(2)
Seidel, Reginald F., 164 Maple st., Englewood (2)
Sklar, Sol H., 647 Anderson av., Cliffside Park (2)
Slabey, Evelyne L., 817 Abbott Blvd., Palisade (2)
Smaine, Enrique Del C., 502 Summit av., Carlstadt(2)
Smalley, Sara D., 530 Clifton av., Newark (7)
Smith, Ellis L., Essex County Hosp., Belleville (7)
Smith, Nelson M., 144 S. Harrison st., E. Orange (7)
Sorett, Joseph, c/o Gen. Delivery, Convent Sta. (7)
Stetser Leland M., 922 Haddon av., Collingswood (4)
Strauss, Max, 190 Clinton av., Newark (7)
Susinno, Anthony N., 29 Roff av., Palisades Pk. (2)
Taylor, Harold W., 247 Mountain rd., Englewood (2)
Timlin, James W., 64 Beach st., Arlington (9)
Toscano George A., 305 Union st., Hackensack (2)
Vargish, Hildegard S., Kinderkam'k rd., N.B'rg'n(2)
Vargish, Jacob, Kinderkamack rd., N. Bergen (2)
Venturo, Ralph, 1332 Ritner st., Philadelphia (8)
Wallack, Charles A., 23 Treacy av., Newark (7)
Wegrocki, Adolph, 588 Sanford av., Newark (7)
Winder, Miles S., 601 Grand av., Asbury Park (13)
Wood, Oram, 128 W. Broad st., Paulsboro (8)
Wright Robert E., 172 Concord dr., River Edge (7)
Wright, Walter A., 2 Broad st., Bloomfield (7)

ASSOCIATES

Fullilove, Robert E., Jr., 24 Waverly av., Newark(7)
Gadek, Raymond J., c/o V. A. Hospital, Lyons (12)
Kieswetter, Dayton T., 75 Prospect st., E. Orange (7)
Paret, Frank J., 108 Church st., New Brunswick(12)
Stanley, Thomas A., 77 Beech st., East Orange (7)

THE BULLETIN BOARD

"THE ACADEMY OF MEDICINE OF THE RARITAN BAY AREA"

The physicians of the Perth Amboy district have formed "The Academy of Medicine of the Raritan Bay Area". The principal aims of the new Academy are the advancement of the science and art of medicine, the maintenance of a medical library, and the promotion of public health and medical education.

In its initial phases, the Academy plans to sponsor a Public Health Week exhibit, to arrange medical lectures for the profession itself, to provide further post-graduate opportunities for physicians in cooperation with Rutgers University and the county and state societies, and to negotiate with the public library in Perth Amboy for the establishment of a special section of the library for the use of the doctors and the public in studying medical and health literature.

Membership in the Academy will be available only to graduates of grade A medical schools who are members of the county and state societies.

Officers of the Academy are: President, Dr. Samuel Berkow; vice-president, Dr. Malcolm Dunham; treasurer, Dr. Joseph Gutowski; secretary, Dr. Jack Shangold.

* * * * *

WHITHER GENERAL PRACTICE?

The National Conference of County Medical Society Officers—familiarly known as the "Grass Roots Conference"—was held in connection with the interim sessions of the A.M.A. at Cleveland on January 6. The discussion was devoted to the general practitioner and his problems. The session took on the aspect of a free-for-all town meeting, where nearly everyone had something to say and a good part of it was well worth hearing.

Most of the speakers were conscious of the dilemma facing the general practitioner today. The horns of this dilemma seem to be: first, that the body of medical knowledge has become so extensive that no man can absorb more than a fundamental understanding of all its specialized branches; and, second, that unless the general practitioner is to be merely a sort of referring station for specialists, he must somehow acquire a better working knowledge of special technics.

Repeatedly, various speakers returned to the root difficulty: — the failure of medical schools to train students for general practice and to aim them in that direction. It was asserted again and again that the medical school *can* train a good general practitioner and make him want to be a general practitioner and even help him find a place for general practice. But it was felt that the medical student comes into constant contact almost exclusively with specialists. The assumption seems to be, almost from the beginning of his school career, that the student is aiming at a specialty and will continue in that direction.

Some of the speakers seemed to feel that until the overall rate of production of doctors is increased, there will not be much opportunity to train more general practitioners. Others mentioned the need of community subsidies to attract practitioners to the smaller towns, as well as their need of modern hospital facilities —so often lacking—when they get there.

There was a good deal of emphasis on the need of hospital appointments, and of more direct recognition for general practitioners in hospital staff organization. All in all, one gained the impression from this lively discussion that the life of the general practitioner these days is not an easy one. The thought seemed to be that the general practitioner is suffering from something of an inferiority complex, caused by the policies of the specialty boards, the trends in hospital staff organization, the belittling of general practitioners by advocates of socialized medicine (and by proponents of group practice) as well as by many other factors — professional, social and economic.

Not everyone took a dim view of the general practitioner's future. It was suggested that if the general practitioner will go to medical meetings, take part in his society's activities, systematize his work, allow more time for new patients, consciously aspire to recapture his former status as a real family doctor and play the part of a leader in his community for the sake of his profession and its future—then he will inevitably find himself back in the driver's seat in medical affairs. There seemed to be pretty general agreement that that's where the general practitioner belongs.

WHAT IS A MEDICAL SOCIETY?

Recently, Dr. Creighton Barker, Secretary of the Connecticut State Medical Society, gave the following description of a medical society:

"The people who make up a medical society are something special, all educated, mostly intelligent, quaintly conceited, strictly individualists, usually with a common interest, and peculiarly unselfish. Mix them all up and add a few honest and some bogus idealists, and a spatter of the unscrupulous and you have a medical society, an organization, the like of which is hard to find."

If you can give a better definition, send it in.

* * * * *

THOUGHTS ON HEALTH EDUCATION

Dr. Charles H. Mayo once said, "I believe the doctors are always at fault when the public does not understand them". This may be an exaggeration but it reflects a wholesome attitude.

Most doctors have long been aware of the need of imparting to individual patients a certain amount of what might be called health education. They must, of course, give the patient some understanding of what is wrong with him and why a certain course of action is proposed. After all the patient has the first and last word in any problem involving diagnosis and treatment. It is the patient's own initiative that presents him to the doctor in the first place, and it is his confidence in the doctor, qualified by his understanding of the doctor's instructions, that determines whether he will follow out the recommended regimen of treatment.

The collective education of patients through the various types of health education imparted to or perpetrated upon the public these days, is something else again.

Much of what passes for health education is special pleading on behalf of some commercial product; another large part of health educational literature is compounded of sensational overstatements calculated to sell an article to a publisher. Soundly conceived plans of health education sponsored by medical societies and other similar groups are usually so poorly financed or badly organized that the result is negligible or sporadic at best.

Small wonder that many physicians mistrust what they think of as health education, as outright encouragement to self-diagnosis and self-treatment. They believe, with some cause, that health education stimulates hypochondriac tendencies and tends to create abnormal fears.

Nevertheless, through the medium of radio and utilizing valuable space generously contributed by newspaper publishers, medical societies are gradually developing modern, effective technics of educating the public on essential matters of health.

It is astounding how much the general public has found out about medicine and medical care in the last decade or two. Of course, much of what the public has learned simply isn't true. But the average patient is not only readier to submit himself to medical care and early diagnosis today than he used to be—he also has a keener and better informed appreciation of what medicine can do for him. The enormous public response to the city-wide diphtheria immunization drive in New York City about two years ago would have been impossible except for the progress made in public health education in recent years.

Increasingly the public is demonstrating its confidence in medical science and medical practitioners, based on a better understanding of what we have to offer. Common sense and the efforts of disinterested people in this field seem to be succeeding in separating the wheat from the chaff.

Progress is being made in public health education. But the job, insofar as it concerns doctors of medicine and their professional societies, has only just begun.

* * * * * *

"THE JOB OF THE COUNTY MEDICAL SOCIETY"

The Third National Conference of County Medical Society Officers will be held on Sunday, June 20, the day before the opening of the A.M.A. session, in Chicago. Under the chairmanship of Dr. M. A. Mitchell of Terre Haute, Indiana, this third "Grass Roots Conference" will be devoted to three panel discussions of the "Job of the County Medical Society". The three topics under consideration will be "The Part of the County Medical Society in Medical Organization," "Its Responsibility to Its Membership", and "Its Responsibility to the Public". Registration will open at the Palmer House at 1:30 p. m., and the sessions will begin at 2:00, ending at 5:30. A detailed program will be published in the *Journal A.M.A.* It is hoped that many county medical society officers from New Jersey will be present at this meeting.

James E. Bryan,
Executive Officer.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

VENEREAL DISEASE DIAGNOSTIC AND TREATMENT SERVICE

Physicians in the southern part of the state will be interested in the announcement of a new diagnostic and treatment service for syphilis and for other venereal diseases at the Institute for the Study of Venereal Diseases, University of Pennsylvania, Philadelphia. A circular describing the service will be sent upon request to Dr. John H. Stokes, Director of the Institute.

Through a research grant, the Institute is interested in problem cases for study, particularly all forms of late symptomatic syphilis. Diagnosis only or diagnosis and treatment are available. If the physician requests, the patient is given a diagnostic workup and then sent back to the physician with recommendations for treatment. There is a charge for this diagnostic service. If, following the diagnostic workup, the patient is found to be eligible for the research project (late symptomatic syphilis) he may be hospitalized and treated at the Institute free of charge, with the understanding that he will return regularly for observation following treatment. If his classification does not make him eligible for the research project, he may be hospitalized for treatment, but at his own expense.

PENICILLIN TREATMENT FOR SYPHILIS

The Division of Venereal Disease Control, State Department of Health, has a small supply of POB (penicillin in oil and beeswax) which has been made available to a group of physicians for the treatment of early syphilis in office practice. If the plan works out, and as funds become available, penicillin for ambulatory treatment will be offered to other physicians.

For this experiment in providing penicillin for ambulatory treatment, 185 physicians were chosen on the basis of having reported at least five cases of syphilis in 1947. It was hoped in this way to reach the physicians most likely to have cases of early syphilis in their care. Only cases of less than one year's duration or cases of syphilis in pregnancy (without adequate treatment previously) are eligible for this state assistance at present.

PREVENTING HEMOLYSIS OF SEROLOGY SPECIMENS

During the winter months the Bureau of Bacteriology received an unusually large number of specimens of blood which had hemolyzed. The freezing of the blood specimen is only one of a number of causes for this condition. General precautions to prevent hemolysis are here outlined. Physicians receiving reports of hemolyzed specimens are offered the following suggestions:

1. The specimen should not be exposed to freezing temperature or to extremely warm temperature for any length of time.
2. If a syringe is used, be sure the needle and syringe are perfectly dry.
3. Do not fill the tube so full that the insertion of the cork causes pressure.
4. Do not expel the blood through the needle. Disconnect the needle and allow the blood to flow gently from the syringe. Forcible expulsion ruptures the blood cells.
5. Collect blood before breakfast, preferably, or before meals. Do not take specimen during digestive period.
6. Allow the specimen to clot in a cool place and keep in the refrigerator until mailing time.
7. Mail specimens so that they will reach the laboratory in the shortest possible time. Avoid mailing on Friday, Saturday or Sunday, or before a holiday.
8. Be sure that the tube is securely stoppered, that the absorbent material has been replaced around the tube and that the mailing container cap is screwed on securely.

Observance of these suggestions will aid in the prevention of the disappointment of a hemolyzed specimen report and will insure the safe arrival of the blood specimen in a satisfactory condition in the laboratory.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

The Medical Society of Atlantic County held its regular meeting at the Traymore Hotel on March 11, 1948. The president, DR. CLARENCE WHIMS, presided. DR. ALLAN PEPPLE, formerly chief of dermatology, Percy Jones General Hospital, Battle Creek, Michigan, spoke on *Contact Dermatitis.*

Contact dermatitis or eczematous dermatitis is very common. It is a disease chiefly involving the skin and its appendages or epidermis. The primary lesion is a vesiculation caused by direct contact of such substances as plant oils, metallic salts, dyes, chemicals, etc. This dermatitis is distinct from the primary skin irritants such as caused from exposure to acids, alkalies and other irritants. It may take from 5 days to ten years of exposure to bring on the sensitization. He stressed that contact is essential to the development of dermatitis and beautifully illustrated by excellent pictures the various lesions produced by the offending allergens.

The specific irritants, as illustrated were plants and pollens such as rag-weed group, i. e. poison ivy, oak and sumac. The percentage of reactions to these allergens varies from 65 to 75 per cent. Cases were mentioned and the lesions were illustrated by Dr. Pepple. In the treatment, avoidance of exposure was stressed. When a patient is exposed it is useless to wash off the oleo-resins. The application of soothing lotions and compresses is indicated. Injections during the acute stage do not help but usually aggravate the condition. Oral prophylaxis may help between 50 to 80 per cent, but it takes a long time and is very tedious. The use of chemical weed killer sprays may be the answer to the problem.

Other antigens as possible causes are legion and Dr. Pepple discussed a large group of them. He told how the Patch Test is used to find out the offending allergen.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society,* held at Bergen Pines Hospital, Oradell, on the evening of March 9, 1948, was called to order by the president, DR. RUDOLPH C. SCHRETZMANN, at 9:15 p. m.

Minutes of the regular meeting of February 10, were accepted as read by the secretary. The minutes of the Executive Committee meeting of February 17 were approved as published in the Bulletin.

The proposed Delegates and Alternates for the 1948-1950 class to the House of Delegates of The Medical Society of New Jersey, and Delegate and Alternate to the State Nominating Committee were read by the Secretary.

On recommendation of the membership committee, the following applicants were elected to full membership: DRS. WALTER LICHTENBERG, Westwood, by transfer from New York County, N. Y.; DR. LOUIS DE LUCA, Ridgewood; DR. BERNARD ROSS, Maywood; DR. MICHAEL J. RUSIN, Garfield.

Dr. Schretzmann announced that the post-graduate course of lectures has been very well attended, seventy-three members registering for the course. He also reported that the enrollment for accident and health insurance policies is now open, and eligible members included those who are uninsurable risks and who may be accepted without a physical examination. Those who have one of these policies may increase their benefits if they wish. The benefits are now up to $400.00 a month instead of $300.00. He urged those who do not have a policy to file an application for one.

The secretary announced that the Bergen County Medical Society was host this evening to the Bergen County Dental Society. The president introduced DR. ROYAL DREWS, president of the Bergen County Dental Society, who said that it was a pleasure to have the two societies meet together. He also said that it had been a long time since both organizations had met together, and emphasized that more cooperation should be shown between the two organizations.

Dr. George M. Knowles, chairman of the scientific committee, introduced the following doctors and dentists who formed the panel for the round table discussion of the evening, on *Constitutional Disease with Oral Manifestations*: Chairman, DR. LEE SOLWORTH, Englewood Hospital; DRS. OTTO S. HENSLE, director, department of otolaryngology, Hackensack Hospital; CLIFFORD L. WHITMAN, D.D.S., F.I.C.D., Hackensack, instructor in orthodontics, College of Dentistry, Columbia University, Member of North Eastern Orthodontic Society, Member of American Orthodontic Society; CHRISTIAN P. SEGARD, medical director of Wisconsin Research Foundation; LESLIE FITZSIMMONS, D.D.S., East Orange, Member, American Academy of Dental Medicine, Diplomate, American Academy of Periodontology, photographer to cancer clinic of St. Michael's Hospital, Newark; J. LOWRY MILLER, assistant clinical professor of dermatology, College of Physicians and Surgeons, chief, dermatology clinic of Vanderbilt Clinic, New York City, attending dermatologist, Presbyterian Hospital; HENRY W. MUSTERMANN, D.D.S., associate professor, radiology, New York University Medical College; ROYAL W. DREWS, D.D.S., President, Bergen County Dental Society. This program was very interesting and very well received by the audience as evidenced by the many questions asked and discussions carried on.

BURLINGTON COUNTY

T. Bruce Dickson, M.D., Reporter

At the Riverton Country Club on March 11, 1948, the *Burlington County Medical Society* held a round table discussion on *Cancer.* The general public was cordially invited to attend and take part in this meeting, which had been advertised in the newspapers of Burlington and Camden Counties. This was the third educational program on cancer sponsored by the Burlington County Medical So-

ciety this year. DR. E. WARREN RODMAN called the meeting to order and introduced the panel of the round table who were: DR. L. S. SNEGIREFF, medical director of the American Cancer Society, New Jersey Division, who acted as moderator; DR. FRANCIS F. BORZELL, vice-speaker of the House of Delegates of American Medical Association; DR. E. W. RODMAN, president of the Burlington County Medical Society; DR. J. HOWARD HORNBERGER, president-elect of The Medical Society of New Jersey; DR. LUIS E. VITERI, internist at the Burlington County Hospital; DR. HAMMELL SHIPPS, gynecologist, Cooper and Zurbrugg Hospitals.

After introducing the panel, Dr. Rodman presented Mr. J. J. Robinson of Palmyra who is chairman of the Burlington County committee on cancer. Mr. Robinson made a short speech outlining the purposes and aims of his committee and thanked the physicians for the active part they are taking in the cancer control program. Dr. William E. Bray, chairman of the public relations committee. took the floor and turned the meeting over to the moderator of the panel, Dr. L. S. Snegireff. Under the guidance of the moderator.the panel discussed: biopsy; breast cancer; skin cancer; x-ray and radium therapy; cancer of the female generative organs; and cancer of the gastrointestinal tract. The early signs and symptoms of each of the above subjects were stressed and the urgency of consulting a physician immediately was emphasized. The part which Burlington County is playing in cancer control was described. In winding up the round table discussion it was recommended that every adult should have a complete physical examination at least once a year.

After the panel had finished the public was asked to submit questions to the panel which were promptly answered. It was a very successful meeting if public attendance and response can be used as indications.

After a ten minute recess the Burlington County Medical Society reconvened and held its regular business meeting in closed session. Dr. E. Warren Rodman presided and thanked Drs. William E. Bray and Paul R. Sparks for the fine work they did in connection with all three round table discussions. Dr. Rodman then introduced DR. ROYAL A. SCHAAF, president of the State Society. Dr. Schaaf who had been present during the first part of the meeting praised the discussion and stated that it is the only way to bring the problem of cancer before the public eye. The real reason for Dr. Schaaf's visit was to warn the Society of the dangers lurking in the reorganization of professional boards which is being attempted under the new State Constitution. Formerly there were ninety boards of licensure under the old Constitution and these have to be condensed to fifteen. At the present moment political pressure is trying to put the medical board of licensure under the control of a non-medical commissioner. This state now has one of the most exacting boards of medical examiners in the country. If the control of this board is taken away from the profession it will mean the loss of this high standard. In the last year or two there has been political pressure brought to bear to lower these standards but so far the State Medical Society has been able to defeat them. In order to preserve the autonomy and integrity of the existing board it must be kept free from political pressure. To do this the Council of Allied Professions, which is composed of medical, dental, veterinarian, architectural, landscaping, nursing, mining, law, and engineering examining boards, favors the establishment of a separate department of professional boards. Dr. Schaaf urgently asked the members to contact their State Senators and Assemblymen to aid in the formation of this new department.

DR. ALDRICH C. CROWE, second vice-president of the State Society, paid us an official visit and outlined the program and the aims of the State Society.

Dr. L. S. Snegireff give a brief resume of the state cancer program.

Dr. Francis F. Borzell brought greetings from the House of Delegates of the American Medical Association and told of the purpose of the conferences of the Medical Societies of the Middle Atlantic States.

Dr. Howard Curtis, secretary of the County Society, read a letter from Veterans Administration in regard to emergency admissions to the Veterans Hospital at Lyons. If any such emergency should arise the physician should call the hospital direct because only the hospital authorities have the power to make such admissions.

CAMDEN COUNTY

Harold K. Eynon, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was called to order at 9:00 p. m. on February 3, 1948, with DR. SHIPMAN, president, presiding. The society approved the sending of a recommendation to Governor Driscoll favoring the appointment of Dr. J. Lynn Mahaffey as Commissioner of Health of New Jersey. On majority approval, the society has retained Mr. Allan R. Eckman as Executive Secretary and Public Relations Counsel for one year beginning April 1, 1948. It is felt that the growth of the Camden County Society and its many varied interests which appear to be increasing from year to year makes necessary the assistance of a professional lay secretary in order to maintain continued progress in our activities. Mr. Eckman has vast experience as a Public Relations Counsel and it is felt that he is exceedingly well fitted for the high ethical conduct of this office.

The scientific program consisted of a discussion of the bacterial and fungus infections of the skin and their management in general practice by DR. DONALD M. PILLSBURY, professor of dermatology and syphilology at the University of Pennsylvania. The paper was well received and provoked extensive discussions and questions.

The regular monthly meeting of the *Camden County Medical Society* was held on March 2, 1948. This meeting, being designated as Hospital Night, was held at the West Jersey Hospital, Camden. DR. SHIPMAN, president, presided. The only business transacted at the meeting was the receiving of two new members into the society: DR. MARK

Brown of Haddon Heights, and Dr. Ned Shaw of Camden.

The meeting was then turned over to the scientific program committee with Dr. Stanley L. Brown, F.A.C.S., chief of Orthopedic Surgery at West Jersey Hospital, presiding. The program consisted of:

1. Spastic Paraplegia — Nicholas G. Frignito, M.D. This was a diagnostic problem in an elderly male with spastic paraplegia of the lower extremities only and concluded to be non-specific degenerative disease of the lateral corticospinal tract not uncommonly found in later life.

2. Incidence of Leukemia — Herman Fischer, M.D. There has been an apparent definite increase in the number of cases of leukemia seen at West Jersey Hospital during the past eight years. No definite cause can be determined. Two questions were raised for discussion, namely: As to whether this increase was due to improved diagnostic methods or an actual increase in the disease incidence with the possibility of the newer drugs as causative factors.

3. Obscure Gastro-Intestinal Bleeding — Harry A. Pinsky, M.D. This was an extremely interesting diagnostic problem which after considerable work and two exploratory laparotomies was determined to be early Banti's syndrome.

4. Congenital Abnormality—Edmund C. Hessert, M.D., F.A.C.S. Dr. Hessert described and illustrated by lantern a patient with complete congenital double uteri with vaginal septum.

5. Severe Preeclampsia with Complications and Treatment—Samuel Goldman, M.D., F.A.C.S., and L. M. Stetser, M.D. This was a careful and complete discussion of the problem of eclampsia state with its management and the citation of cases.

6. Carcinoma of Leg Following Burns—H. Wesley Jack, M.D., F.A.C.S. Dr. Jack presented the case report of a youth who had been severely burned on both legs, who had been skin grafted and who developed carcinoma at the site of the skin graft. There was no previous evidence of malignancy and no other site of malignancy determined.

CAMDEN COUNTY

Following is an extract of a report by Dr. Joseph B. Reilly of Oaklyn on the possibilities of the full utilization of the Camden County Institutions at Lakeland, N. J.

Recently I made an inspection of the Camden County Institutions at Lakeland. I was surprised and disappointed with my findings. Surprised at the vastness of the plant situated on a tract of seven-hundred acres, with many substantially constructed and well equipped buildings for housing the sick and aged. Disappointed because of the rows of unused beds, and the lack of sufficient staff physicians properly to treat the hospitalized patients.

The general hospital is well equipped for the treatment of acute medical and surgical illnesses. This building has a capacity of about four hundred, but only one hundred and sixty beds are regularly in use. Most of these patients are chronically ill, and have been at Lakeland ten or more years. The building has seven floors, the first and sixth are not used for patients, although they are equipped for that purpose. There are two beautiful and modern operating rooms, scrub room, and numerous cabinets of surgical instruments practically never used.

The tuberculosis preventorium for children was last occupied in 1943. It contains class rooms, complete kitchen, and two large wards, all empty and serving no purpose.

The mental hospital is full to capacity, having at present 750 patients—more than half of these are potentially curable, and deserving of the best psychiatric care. In October 1947, a full time resident psychiatrist was obtained. However, before October 1947, the mental hospital was without a resident psychiatrist. The needs of seven hundred and fifty mental patients, must therefore be met by one full-time man: an impossible task!

The building for adult tuberculosis patients has a minimum capacity of two hundred and thirty-seven, at present there are one hundred and sixty patients. This structure has two well equipped operating rooms, used very little, due to lack of physicians trained in thoracic surgery.

Lakeland is hopelessly under-staffed both as to resident and visiting physicians. The county says that it cannot afford to utilize Lakeland to capacity, and employ the necessary personnel, without increasing the burden on the taxpayer. As an alternative, it has been suggested, the institution be turned over to the state. I do not agree with either of these. The magnificent facilities at Lakeland can be fully utilized, for the benefit of the people of Camden County without a tax increase, and there is no need to deprive ourselves of such a great institution by transferring it to the state.

The building fully equipped for the care of acutely ill patients, could be used as an acute hospital for the private patients, and called, let us say, The Camden County General Hospital. An adjoining building could be connected by an underpass and used as wards. Thus the operating rooms, etc., in the one structure would serve the two buildings. Physicians who desired to send private patients to this hospital, would be required to give the county several hours each week, in caring for the patients in the other institutions of the group. Such an arrangement is used in most hospitals as a requirement for staff membership. Lakeland would be flooded with physicians and surgeons willing to give some of their time, caring for those unable to pay and in return, would be provided with a hospital for their private patients. At present many physicians must send their patients outside the county to be hospitalized. By such a plan the urgent need for more hospital beds in the county would be considerably diminished. Camden County would receive substantial income from the hospital for private patients, and those able to pay little or nothing for their care, would receive adequate medical attention. The income from private patients would help to pay the expense of the entire institution, and the burden on the tax payer would be definitely reduced.

J. B. Reilly, M.D.

CUMBERLAND COUNTY

E. C. Greene, M.D., Reporter

A paper on the history of the *Cumberland County Medical Society* entitled *130 Years of Service* prepared by DR. MARY BACON, secretary of the society, was a feature of the organization's Ladies' Night dinner meeting held March 17, 1948, in the ballroom of the Hotel Cumberland, Bridgeton.

STATE SENATOR ELMER H. WENE was guest of honor at the affair and the guest speaker was HOWARD MCNABB, humorist, who was presented as a "former Mayor of Manayunk". DR. CHARLES CUNNINGHAM, of Vineland, was toastmaster, and DR. SIDNEY SIEGEL, of Millville, president, opened the evening's festivities with a few words of welcome.

Dr. Bacon's paper revealed that the Cumberland County Medical Society was organized in 1818, with DR. EBENEZER ELMER as the first president.

Disbanded in 1830, the society was reorganized November 28, 1848, and this year rounds out 100 consecutive years of operation. The doctors responsible for the reorganization were Dr. Enoch Fithian, Dr. William S. Bowen, Dr. William Elmer, II, Dr. George Tomlinson, Dr. J. Barron Potter, Dr. Eli Bateman, Dr. Rush Bateman, Dr. Ephraim Buck, Dr. Jacob W. Ludlum and Dr. Charles Butcher.

The last named is a forebear of Dr. Charles Butcher, of Heislerville, and according to Dr. Bacon's paper, the records show that there has been a Dr. Butcher in the vicinity of Heislerville since Dr. Joseph Butcher practiced there in 1826.

Mention was made of the long period of service rendered the society by DR. HERBERT WILSON, who has been treasurer continuously since October 7, 1924.

Speeches and dancing followed the dinner, with Serra's Orchestra of Vineland providing the music.

The committee on arrangements included Dr. Cunningham, Dr. Bacon and Dr. Carl Ware.

GLOUCESTER COUNTY

L. K. Collins, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held February 19 at the Woodbury Country Club, with DR. JOSEPH F. HUGHES presiding. DR. JOHN M. WILCOX of Pitman was elected to membership in the society.

Dr. Wendell Burkett, chairman of the legislative committee, gave his report which was chiefly concerned with the future status of the various professional licensing boards. The society felt that the medical board, even though coming under the jurisdiction of the new State Department, should retain its autonomy. The secretary was instructed to write to the Board of Trustees of the State Medical Society expressing the above opinion, but also stating that we would go along with any plan that the State Society had in this matter.

The scientific program consisted of a discussion by CHARLES C. WOLFERTH, M.D., University of Pennsylvania, on "Recent Advances in Cardiac Diagnosis and Treatment". Dr. Wolferth first went into some of the newer research such as heart catheterization for determining pressure and oxygen concentration; also mentioned was angiogrophy and the refined technic of motion pictures of the fluoroscopic screen. The four cardinal principles in the treatment of congestive heart failure were emphasized, namely: salt free diet; two to three quarts of water daily; digitalis; and mercurial diuretics. The recent advance in acute coronary disease is anticoagulant therapy which Dr. Wolferth thought should be reserved for very early cases. The antibiotics were mentioned in the treatment of cardio-vascular lues and in subacute bacterial endocarditis. Then followed a discussion of cardiac surgery for patent ductus arteriosus, for "blue babies", for coarctation of the aorta, and for mitral stenosis. During the question period, surgery for hypertension was explained.

DR. JOSEPH HUGHES presided at the regular monthly meeting of the *Gloucester County Medical Society* held at the Woodbury Country Club, March 18, 1948, at 9 p. m. Dr. Wendell Burkett reporting for the legislative committee suggested the society approve the new bill creating County Boards of Health. Dr. Burkett explained that this would cost most municipalities more money but that one half was to be borne by the State Department of Health. The motion was carried.

Dr. William Pedrick then stated that he had been appointed spokesman for the various school physicians in the county; he discussed their reaction to the four-point program for the improvement of school health. The school physicians expect to participate as far as possible in this program, leaving the question of stripping to the waist in the hands of the local authorities.

The scientific section was then turned over to MERLE M. MILLER, M.D., assistant professor of medicine, Graduate School, University of Pennsylvania, who discussed the "Newer Aspects of Allergy". Dr. Miller really went through the whole problem of allergy from definitions, theories, types, up to the newer anti-histamines. The cases of gastro-intestinal allergy presented with x-rays were very interesting, although such clearcut cases and cures were in the minority. The evening concluded with a lively question and answer period.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting on February 3, 1948, at the Jersey City Masonic Club. DR. DRISCOLL presided.

DR. ROBERT T. SHIPMAN of Jersey City was elected to membership.

As chairman of the committee on postgraduate medical education, DR. GEORGE GINSBERG submitted a preliminary report on the course in postgraduate medicine that is to be presented by the Society in cooperation with Rutgers University. Lecturers and their subjects are as follows:

April 2. IRVING SHERWOOD WRIGHT, M.D.
Use of Anticoagulant Drugs in Diseases of the Heart and Blood Vessels.

April 9. EDWARD WEISS, M.D.
Psychotherapy in Medical Practice.

April 16. George M. Lewis, M.D.
What's New in Dermatology.

April 23. John H. Garlock, M.D.
Recent Advances in Gastrointestinal Surgery.

April 30. Byron Stookey, M.D.
Indications for Surgery in Diseases of the Nervous System.

May 7. Leslie O. Ashton, M.D.
Etiology and Treatment of Nutritional Anemias in Infancy and Childhood.

As guest speaker of the evening, Raphael Kurzrok, Ph.D., M.D., attending obstetrician and gynecologist at Morrisania Hospital, New York City, discussed *Recent Advances in Obstetrics and Gynecology,* presenting his subject in two parts. He first spoke on the treatment of repeated miscarriage, using as a basis for discussion, the three types of miscarriage that occur on a functional basis. He devoted the second part of his talk to a detailed discussion of hyaluronidase, described as a new enzyme essential in fertilization. Its properties were analyzed and the remarkable effects of its presence were shown. The speaker asserted, however, that an improvement in the present method of administering hyaluronidase is one of the hopes of the near future. Drs. Donnelly, D'Acierno, Fliegel and Butler participated in a discussion of the subject from the floor. Upon closing the discussion period, Dr. Kurzrok was given a rising vote of appreciation.

MIDDLESEX COUNTY

Anthony J. Pellicane, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on February 18, 1948, at Roosevelt Hospital, Metuchen, with Dr. Klein, president, presiding.

Dr. John R. Twiss, F.A.C.P., assistant clinical professor of medicine at New York Post-Graduate Medical School, was guest speaker. He spoke on "The Prevention, Diagnosis and Treatment of the Post-Cholecystectomy Syndrome." His talk was illustrated by slides and was most interesting. Dr. Twiss explained at great length the diagnosis and treatment of the cholecystectomy syndrome. The chief sympton of this condition is pain, with discomfort after meals. Once a diagnosis is made, the patient should be operated on as soon as possible. Dr. Twiss went on to explain the contra-indications for cholecystectomy, and surgery in other diseases of the biliary tract.

Dr. R. Franklin Carter, professor of surgery at the New York Post-Graduate Medical School, continued the discussion of the cholecystectomy syndrome. He described the surgeon's problem and explained the functional aspects of the complications. Dr. Carter stated the indications for exploring the common duct run about 36 per cent.

An active discussion from the floor followed these talks, which were enthusiastically received by the large audience present.

At the conclusion of the scientific session, the business meeting was taken up. The January meeting minutes were read and approved without change.

Drs. Benjamin Marino, New Brunswick; Frank Romano, Dunellen, and Ralph Siegel, Perth Amboy, were elected to full membership status from Associate membership.

Dr. George F. Frederick, Woodbridge, was elected to two-year period of Associate membership.

Dr. Martin J. Cook, New Brunswick, was elected to active membership on transfer from the Ingham County Medical Society, Lansing, Michigan; and Dr. Sidney D. Becker, Keyport, from the Monmouth County Medical Society.

The following amendment to the By-Laws was proposed by Dr. Charles H. Calvin, chairman of the committee on medical ethics::

Chapter I: Membership: Section 1:—Classes of Membership: B-Active Members: A physician who has been an Associate Member of the Middlesex County Medical Society for two (2) years shall be eligible for election to Active membership provided: (a) he has resided in New Jersey for at least the year preceding his election; (b) he again has the endorsement of two Active members who reside in his community, or in the next adjoining area if there are not sufficient Active members in his community ;and (c) he meets the requirements of the Committee on Medical Ethics. Active members in good standing shall be entitled to all privileges of membership, including the right to hold office, to vote, and to be a member of appointed or elected committees.

This amendment, having previously been approved by a majority of the Board of Trustees, was regularly moved, seconded and passed for adoption.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The regular monthly meeting of the *Monmouth County Medical Society* was held on Wednesday evening, February 25, 1948, at the Monmouth Memorial Hospital in the auditorium of the Borden Memorial Pavilion. Dr. Samuel Edelson opened the meeting with the scientific program at 9:00 p.m.

Dr. James Pregnall introduced Dr. Heckman, resident, orthopedics of the Monmouth Memorial Hospital. Dr. Heckman presented fifteen cases of fractured hip, describing the types of fracture and the methods of treatment. All but one of these patients were present.

Dr. Robert MacKenzie introduced the speaker of the evening, Dr. Claude E. Heaton, assistant professor of obstetrics and gynecology at the New York University. Dr. Heaton's subject was *Causes and Management of Threatened or Inevitable Abortion and Prevention of Habitual Abortion.* Dr. Heaton divided his cases into early and late abortion. The etiology of these cases may be summarized as being due to factors affecting the ovum, endocrine factors, conditions of genital tract and the general condition of the mother. The control and prevention was discussed. The most important factor in the treatment of inevitable abortion is not to perform a dilation and curettage unless it is definite that the abortion is inevitable. The indications for a dilation and curettage are as follows: incomplete abortion, prolonged bleeding, severe profuse bleeding.

In the treatment of infected abortions, radical

treatment must be avoided in the presence of hemolytic streptococcus and if there is any spread of infection.

General discussion followed the presentation of the paper.

The following doctors have been elected to full membership: DR. FRANCIS HART, Asbury Park; DR. SICA SCHMAIER, Bradley Beach; and DR. LOUIS DE SIMONE, Asbury Park.

A letter from the army requesting physician volunteers for recruiting examinations for the army and air force was read.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday evening, March 16, 1948, at 9:00 p. m. in the Freeholders' Meeting Room, Administration Building, Paterson. The president, LEON E. DE YOE, M.D., presided.

At the business session preceding the scientific session, the following physicians were elected to Active membership: JOHN PAUL DIRR, M.D., Clifton; ROY R. CICCONE, M.D., Passaic; FRIEDRICH ROTHENBERG, M.D., and NORMAN BEIN, M.D., of Paterson. LUCIUS S. TARCHIANI, M.D., of Paterson, was elected to associate membership.

Delegates and Alternates were elected to represent Passaic County at the State Convention in April.

Dr. De Yoe introduced TERESA MCGOVERN, M.D., speaker of the scientific session, whose subject was "Peripheral Vascular Disease". Dr. McGovern is a Diplomate of the American Board of Internal Medicine, and has done considerable research in vascular diseases. She has held teaching positions at New York Post-Graduate Hospital, Columbia University and Goldwater Memorial Hospital. Dr. McGovern devoted most of her talk on peripheral vascular disease to arteriosclerosis obliterans, varicose veins, phlebitis, thrombophlebitis, phlebothrombosis and the post-phlebitic syndrome. Her paper was exceptionally educational and interesting and following her presentation there was much discussion in the form of a question and answer period.

SALEM COUNTY

D. G. Neander, M.D., Reporter

The regular monthly meeting of the *Salem County Medical Society* was held at the DuPont Penns Grove Club on February 20, 1948, at 4:30 p. m. The speaker of the afternoon, DR. ROBERT GARBER, clinical director, New Jersey Hospital, Trenton, was introduced by the president, Dr. William H. Miller. Dr. Garber chose as his subject: "Commitment of Patients: Facilities of the Hospital". He explained the proper usé of the two forms of commitment to the hospital and emphasized the need of accuracy, and the presence of the proper signatures on the paper. The process of the patient's work-up was then described. This work-up includes an initial examination, and the taking of all pertinent information available. Within the next few days, the patient is given a complete physical, mental and psychiatric examination. An effort is made to get the patient into as good physical condition as possible. Before the patient has been in the hospital 30 days, his case is presented to the staff by his attending physician. A diagnosis is made, and a plan of treatment recommended. In addition to fever and shock therapy, refrigeration therapy is now being used. Although it is too early to make any statement as to its effectiveness, the present outlook is encouraging.

Besides treating patients with mental disorders, certain alcoholics and luetics are also treated at the New Jersey Hospital.

At the end of the scientific section, the business portion of the meeting was opened by Dr. Miller. The minutes of the last meeting were approved as read. The society approved a recommendation to sponsor a weekly health column in the local papers. This column will be released by the State Medical Society.

The society also moved to accept an invitation to attend a meeting of the Gloucester County Medical Society to be held on April 15, 1948, at 9:00 p. m., at the Woodbury Country Club. In order to be able to attend this meeting, the members agreed to hold the annual business meeting of the society in March.

SUSSEX COUNTY

Katherine E. Stewart, M.D., Reporter

A regular meeting of the *Sussex County Medical Society,* held at the Sussex Inn, Sussex, on February 24, 1948, was called to order at 9:45 p. m., by the president, DR. MARTIN I. KIRSCHNER.

During the business session, The Medical Society of New Jersey's recommendation that it distribute to the daily and weekly newspapers of the state articles to be published under the title of *Health Hints,* was approved by the society.

On recommendation of the membership committee, DR. GEORGE F. CATLETT of Newton was elected to full membership.

Dr. Leo Drake was appointed as official interpreter of the chest x-rays to be taken by the newly established x-ray unit.

After the business session, MR. JAMES E. BRYAN, executive officer of the State Society, outlined for us the work of the Society. In stressing the importance of public relations, Mr. Bryan stated that the State Society occupies the same relation to the public as the physician does to the patient. He pointed out that too often in the past organized medicine has been famous for its attitude of opposition, but now is taking positive stands on important matters such as the Hill-Burton Act. Mr. Bryan brought to our attention the various State Society projects of the present time. The programs on school health, cancer control, heart disease, child welfare, and post-graduate training were emphasized. Mr. Bryan's informative talk was greatly appreciated.

WOMAN'S AUXILIARY

MRS. ROBERT BYRON WALKER
PRESIDENT 1948-1949

Mrs. Robert Walker was born Inez Acker in Worcester, Massachusetts. After receiving a certificate and teaching Red Cross surgical dressings and first aid during World War I. she decided to enter the nursing profession and in 1920 was graduated from the Christ Hospital in Jersey City and from the New York Lying-In Hospital. She was later named night supervisor at Christ Hospital and two years later accepted the position there as Director of Nurses.

During World War II, Mrs. Walker was monitor for the Red Cross surgical dressings and devoted one evening each week as receptionist at the Camp Kilmer U. S. O.

Mrs. Walker worships in the Episcopal church. She is a member of the Board of Managers of the Middlesex County Chapter, American Cancer Society. She is a member of St. Peter's Hospital Auxiliary and was an officer for eight consecutive years of the Middlesex General Hospital Aid Association, serving two years as president. She is a member of the New Brunswick Woman's Club and the League of Women Voters. She has been active in the Auxiliary to the Middlesex County Medical Society and served as president from 1942-1944 and 1946-47. She was 2nd vice-president of the Auxiliary to The Medical Society of New Jersey 1944-45; Director 1945-47; chairman of publicity 1946-47 and president-elect 1947-48.

Mrs. Walker is interested in the study of the American Indian. She has made many visits to the Indian Reservations, collects Indian



relics and has a sizable library of books relating to the subject.

In 1925 Inez Acker married Dr. Robert Byron Walker of Myersdale, Penna., whose 5th great grandfather immigrated from England in 1720 and located in Frederick, Maryland. His 4th great grandfather was a captain in the war of the Revolution. Dr. and Mrs. Walker have one son, Robert Acker, a fifth form student at the Lawrenceville School.

EXECUTIVE BOARD MEETING

Mrs. Thomas H. McGlade, Chairman, Press and Publicity

Fifty-one members were present at the regular meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey, held on March 8, 1948, at 315 W. State Street, Trenton. Mrs. Lodovico Mancusi-Ungaro presided.

The morning business session comprised the reading of the reports from state chairmen and county presidents, final Convention notices and plans and a request for annual reports.

Edward F. Stegen, Associate Administrator, National Physicians' Committee for the Extension of Medical Service, Chicago, was the speaker of the afternoon. He emphasized the importance of the National Physicians' Committee and the favoring of voluntary planning for illnesses.

Mr. Stegen was introduced by Dr. Joseph F. Londrigan, New Jersey Chairman for the National Physicians' Committee.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **May, 1948** **No. 5**

THE economic importance of controlling tuberculosis is often overlooked because the humanitarian aspect is so compelling. Therefore, it is good to be reminded that it is business organizations, established for profit, which have furnished much of the clearcut unmistakable evidence that the control of tuberculosis is both possible and practical with the means now at our disposal.

TUBERCULOSIS CONTROL IN INDUSTRY

Tuberculosis control among employees of The Eastman Kodak Company was begun in 1921 with a roentgenographic survey of the chests. In 1923 it was enlarged to include periodic roentgenograms of the chests of all employees as well as the examination of applicants.

In a report made by Dr. William A. Sawyer in 1939, this work was reviewed for the years 1923 to 1937. At that time the incidence of active disease per thousand employees in three-year periods was shown to have dropped from 2.08 in the period 1923 to 1925 to 0.47 in the period 1935 to 1937. During the war years the labor turnover was unusually high, and therefore the incidence cannot accurately be determined. In only 18 persons did active pulmonary tuberculosis develop over a period of five years, among employees increasing in number from 6,000 in 1941 to 10,000 in 1945. Though the increment was only 4,000, the number of applicants employed for varying periods of time during the period 1941 to 1945 totaled 20,500. Active pulmonary tuberculosis appeared at all age levels. The ratio of the number of cases in each decade to the percentage in each ten-year group employed is nearly uniform throughout.

Those in the higher age groups might even be regarded as more vulnerable to tuberculosis, since they have been subject to a "weeding out" process over the years. Those who survive have the same attack rate as those aged 20 to 40 years, usually considered to be more vulnerable.

At the present time two per cent of all employees have roentgenograms of the chest classified as indicating pulmonary tuberculosis, minimal inactive.

Following the preemployment roentgenogram, routine 14 by 17 inch roentgenograms are retaken as follows:

Age When Employed	*Years Between Routine Roentgenograms*
To 25 years	1, 3 and 5
25-34 years	2, 3 and 5
35 to retirement	3 and 5 and every 5 years thereafter

In addition roentgenograms are taken after prolonged absense for any reason, and in the presence of suggestive symptoms.

The majority of the group (11 cases) in which active pulmonary tuberculosis developed later had roentgenograms of the chest indicating abnormalities at the time of employment. In three cases this was an "apical cap," a term used to describe a crescentic, homogenous soft tissue density, over the dome of the apex of the lung.

Stage of Disease When Discovered to be Active

The one case of far advanced disease discovered contradicts an oft repeated rule, namely, that a person with a normal roentgenogram of the chest at age 40 will never have active pulmonary tuberculosis. This woman, aged 56 at the time of employment, had what was considered to be an inactive infraclavicular lesion. One year after employment she was taken acutely ill with what appeared to be virus pneumonia. Three weeks after onset of the disease her sputum contained tubercle bacilli, and in six weeks a 5 cm. cavity developed.

Signs and Symptoms Accompanying Active Disease

Each person was carefully interviewed for a history of his disease in retrospect. In only one could the symptoms elicited be said to have been more than suggestive: an acute respiratory infection with a small hemoptysis.

There were two cases in which pneumonia was the presenting symptom. In each instance it was considered to be of the virus type early in its course.

Location and Spread of Lesions

In recent years, the importance and gravity of an infraclavicular lesion have been emphasized. Earlier it was held generally that in adults all pulmonary tuberculosis began in the apex, producing symptoms and signs of "consumption" as the lesion extended downward below the clavicle. In this small series, apparently inactive lesions in both apex and infraclavicular regions have been the starting point of active disease.

Years Between Employment and Tuberculous Activity

In mass surveys the question of frequency of reexamination arises. Do roentgenograms of the chest which are negative and "clinically not significant" for one, three or five years imply lifelong freedom from active disease? The answer is indubitably no; repeated roentgenograms at regular intervals, after prolonged absences and in the presence of suggestive symptoms are indicated. The four persons in whom active pulmonary tuberculosis developed upward of 10 years after their employment had had minimal inactive infection throughout that period; the lesions had appeared hard, and serial roentgenograms had shown no change.

Duration of Treatment

It has long been known that the time required to arrest active pulmonary tuberculosis is closely correlated with the stage of disease when treatment is instituted. Six to 18 months is usually required to arrest minimal lesions. In only two cases of this series was this time exceeded.

All of the minimal infections were treated by rest alone. Pneumothorax was successful in controlling moderately advanced disease, and the person thus affected was returned to work after 18 months, therapeutic pneumothorax being maintained.

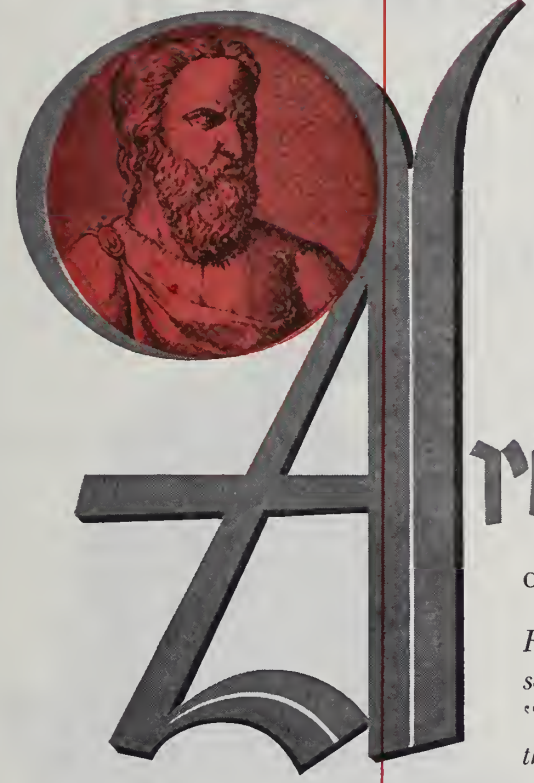
Tuberculosis Control in Industry, Charles R. Allison, M.D., Occupational Medicine, September, 1946.

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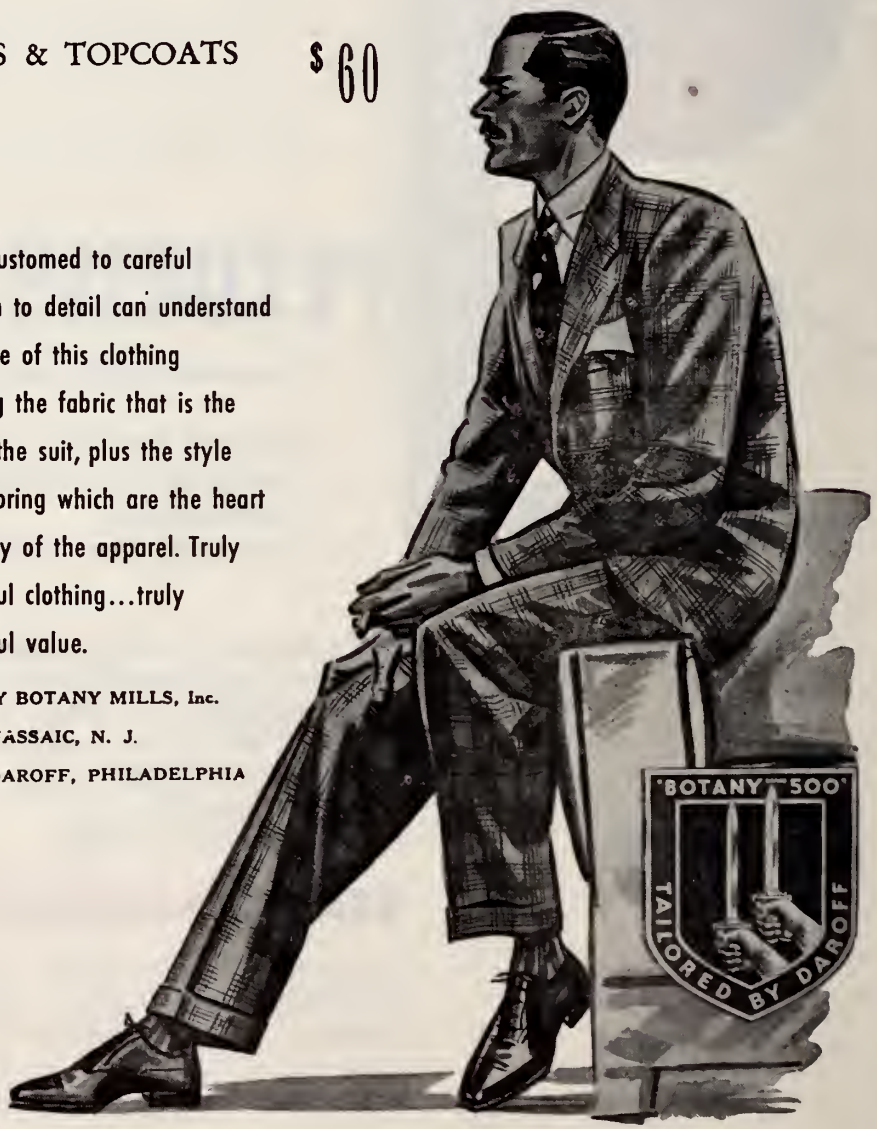
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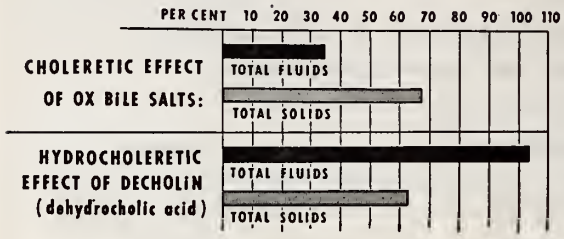
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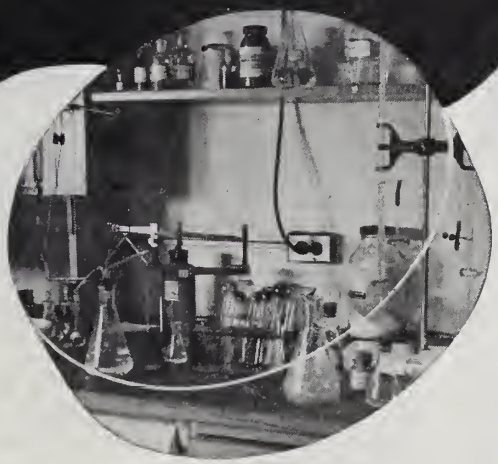
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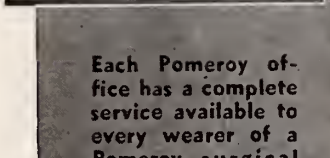


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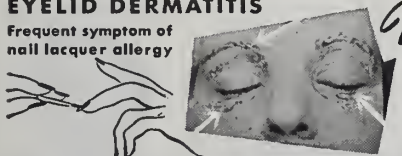
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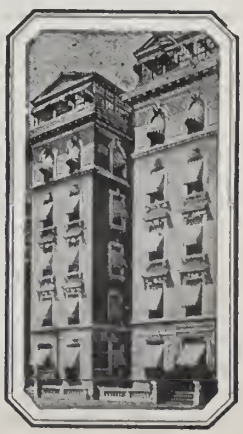
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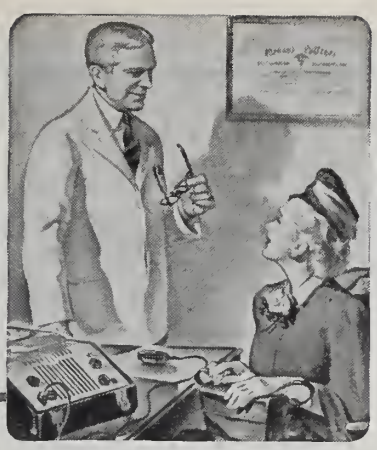
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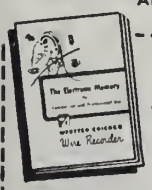
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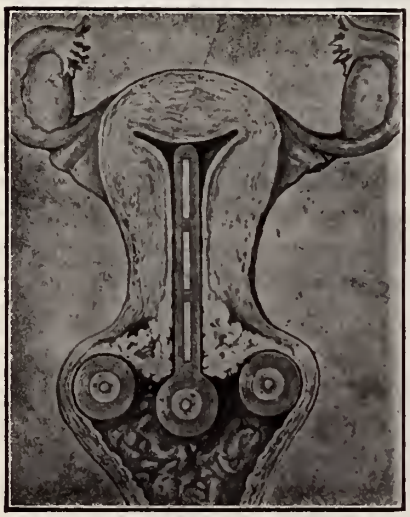
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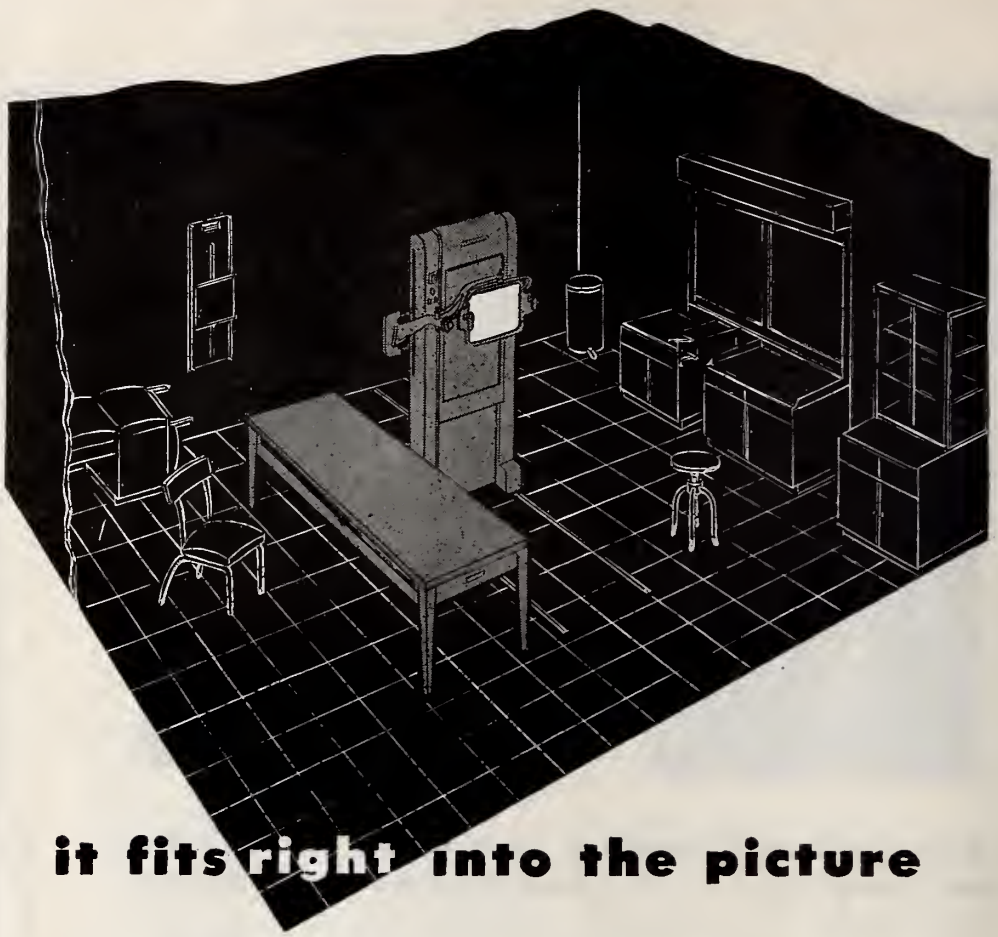
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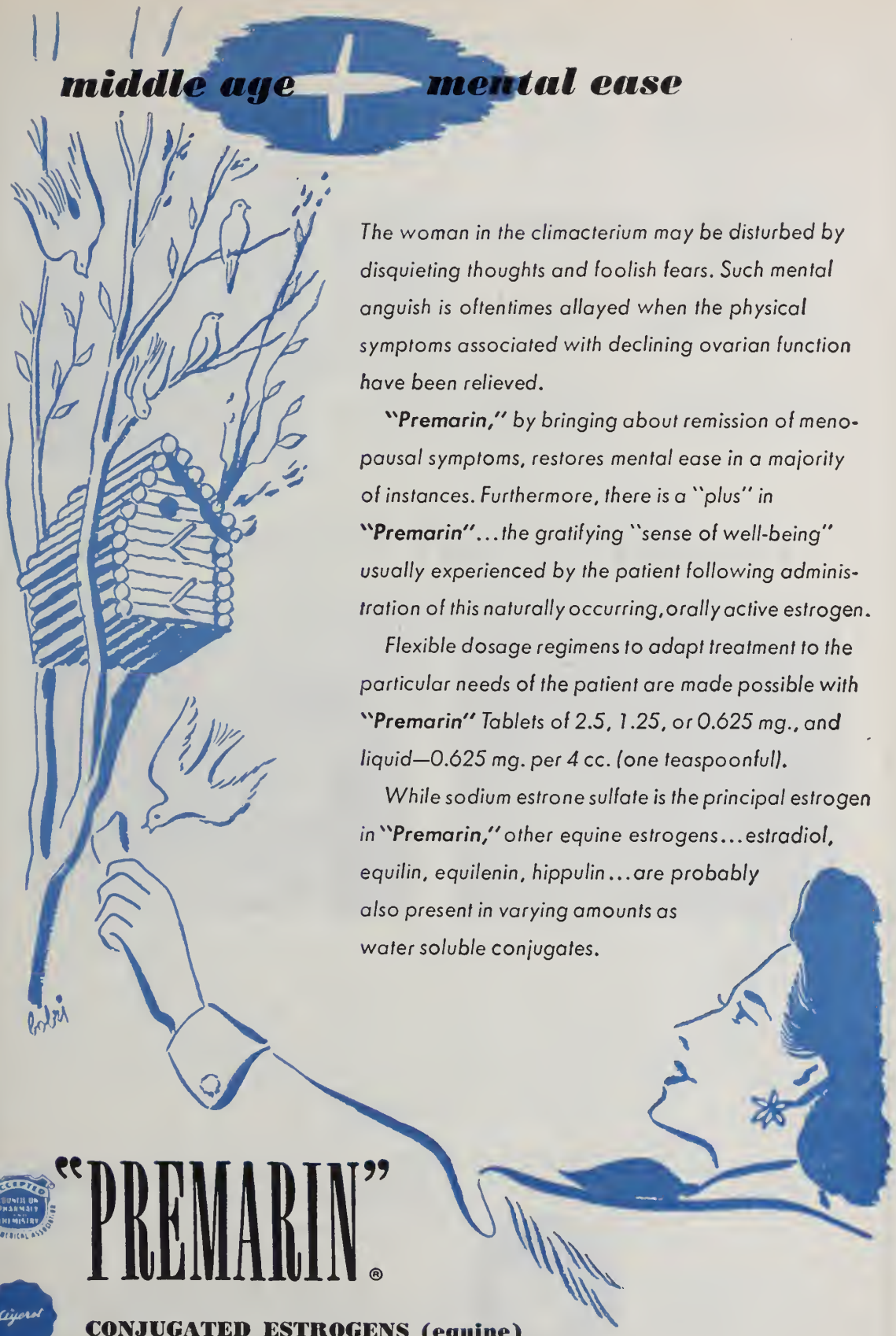
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Paul Ehrlich, expanding on his knowledge gained as a pupil of Koch, concluded from his experiences in the staining of bacteria that there was a close chemical affinity between the cellular body and the stain. This idea led him to believe that specific drugs could be found which would kill invading pathologic organisms, without damage to the host. His conclusions helped create the science of chemotherapy, which is increasingly important today.



Experience is the best teacher in cigarettes too!

Yes! Experience counts—today as always. And with the thousands and thousands of smokers who have tried and compared many different brands of cigarettes, Camels are the "choice of experience."

Try Camels yourself! See how your taste welcomes the rich, full flavor of Camel's choice, properly aged, expertly blended tobaccos. And see how your throat appreciates Camel's cool, cool mildness.

Let your own experience tell you why *more people are smoking Camels than ever before.*



R. J. Reynolds Tob. Co., Winston-Salem, N. C.

According to a Nationwide survey:

More Doctors Smoke CAMELS

than any other cigarette

Three independent research organizations in a nationwide survey asked 113,597 doctors to name the cigarette they smoked. More doctors named Camel than any other brand.

One Day's Food For A WALKER-GORDON COW



CORN SILAGE — 24 lbs.



DEHYDRATED ALFALFA HAY — 8.5



ALFALFA SILAGE — 13 lbs.



GRAIN MIXTURE — 13 lbs.
14 (ingredients)

1. Molasses	1.9 lbs.
2. Mineral	0.1 lb.
3. Salt	0.2 lbs.
4. Soybean Meal	0.5 lbs.
5. Gluten Feed	0.5 lbs.
6. Linseed Meal	0.1 lb.
7. Distillers Grain	0.5 lb.
8. Brewers Grain	0.5 lb.
9. Bran	1.5 lbs.
10. Oats	2. lbs.
11. Corn	1.5 lbs.
12. Babassu Meal	1. lb.
13. Malt Sprout	1.5 lbs.
14. Barley	1.5 lbs.



WATER — 85 quarts

THIS SCIENTIFIC daily ration was developed after years of study by the Walker-Gordon Laboratories.

It is remarkably rich in vitamins and health-giving minerals . . . And that's one big reason why Walker-Gordon cows produce a milk far superior to the type you get from cows that are fed in the ordinary, unscientific way.

Take Vitamin A, for example. The alfalfa fed a Walker-Gordon cow is not ordinary alfalfa, but a special dehydrated kind containing more Vitamin A. As a result, her milk contains more Vitamin A than many ordinary milks.

And though the quantity of some other vitamins varies in ordinary milk (according to the season and what the cows find to eat), the vitamin content remains uniformly high in Walker-Gordon Certified . . . the year 'round.

Then, too, Walker-Gordon Certified is delivered fresher than ordinary milk. This, plus the cows' wonderfully balanced diet, makes its Vitamin C content higher . . . and gives it a much finer, richer taste.

So it's easy to see why more and more physicians recommend Walker-Gordon Certified to their patients. They believe it's well worth a few pennies extra to get this marvelously pure milk with all its added nutritional values.

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THE WORLD'S FINEST MILK

For free illustrated booklet, write to Walker-Gordon, Plainsboro, N. J.



a premium product specifically designed for intravenous feeding

NOW a *lyophilized* protein hydrolysate is offered to the medical profession

This protein hydrolysate is *modified*[1] by a reduction of its glutamic and aspartic acid content—to lessen the likelihood of nausea and vomiting

It presents a *comprehensive statement of composition* on its label

Its "essential amino-acid values" are determined by *microbioassay*

Lyophilized ELAMINE permits *a choice of diluent*

ELAMINE provides more than half of the total amino-acid content as *essential amino acids in their free state*

Each bottle supplies *60 grams* of amino acids

PERCENTAGE COMPOSITION
(average but NOT calculated to 16% Nitrogen)

Arginine*	3.8
Histidine*	2.7
Isoleucine*	8.0
Leucine*	10.6
Lysine*	8.2
Methionine*	3.0
Phenylalanine*	5.1
Threonine*	4.4
DL-Tryptophane	1.0
Valine*	8.1
Other amino acids (approx.)	42% by difference

Total Nitrogen‡	13.4
a-Amino N‡†	10.0
% a-Amino N of Total N‡	75.0
Ash—on ignition	1.0
Moisture	1-2.0
NaCl.....less than	0.5

*By Microbioassay
‡By Chemical Analysis
†Nitrous Acid Method (Van Slyke)

[1]"Modified Protein Hydrolysate" is the generic name given to this type of amino-acid preparation. (See REPORT OF THE COUNCIL, J.A.M.A. 136:692-693, March 6, 1948)

Supply: *Lyophilized* ELAMINE (60 grams per bottle) is packaged 12 bottles per carton. Diluent—I.C. is packaged 12 x 600 cc. bottles. Accessory equipment is available in dozen quantities, e.g., one dozen transfer needles and air vents, one dozen infusion kits.

Write for literature

See Lyophilized ELAMINE at Booth A-127

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MANUFACTURERS OF AMINO ACIDS

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FOR CUSTOMERS' *EXCLUSIVE* USE

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- The container furnished for used diapers while in the home sprinkles contents with an efficient antiseptic solution.
- All operations are carefully checked both chemically and by running regular bacteria colony counts on the diapers.

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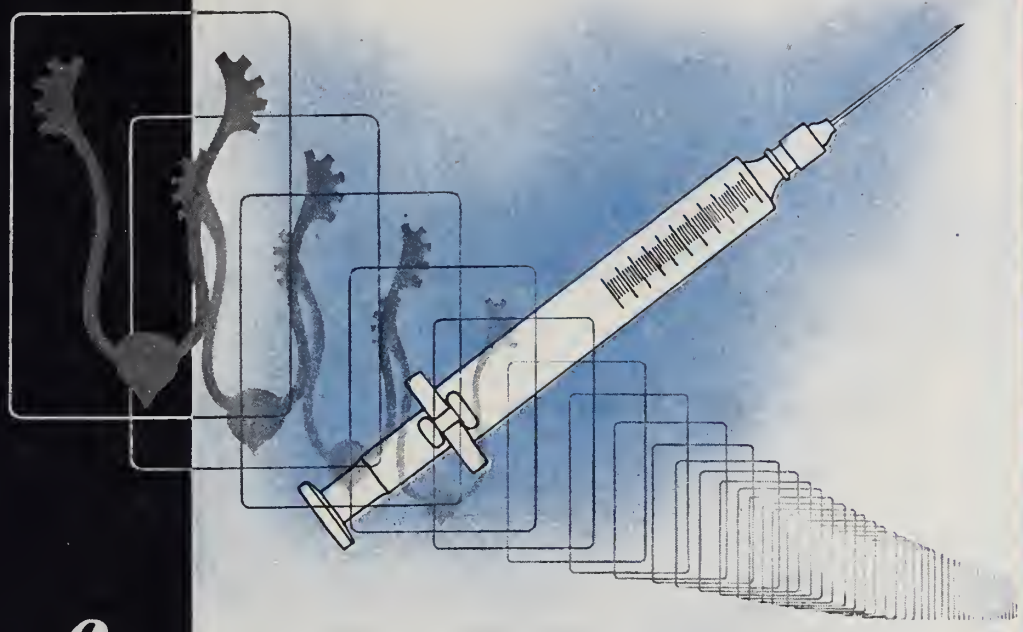
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(disodium N-methyl-3,5-diiodo-chelidamate)

is due to its unique composition and stability, the meticulous care exercised in its preparation, the careful control of all manufacturing stages, and the rigorous inspection of the finished product. Each ampul of NEO-IOPAX is sterile and free from foreign particles.

NEO-IOPAX is available in 10, 20 and 30 cc. ampuls of 50% concentration and 10 and 20 cc. ampuls of 75% concentration. Packaged in boxes of 1, 5 and 20 ampuls.

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There is a way to lighten the burden of nutritional privation in older individuals. The method is the routine prescription of GERILAC to supplement the diet of your elderly patients. This will be particularly appreciated by those with whom material want goes "hand in glove" with advanced age.

At a cost of only 19¢ a day, Gerilac is all the more economical because it does not require mixing with milk. One reliquefied pint of Gerilac provides ⅓ of the proteins, a full allowance of each of the necessary vitamins* and minerals, and 300 calories in two 8-ounce glasses of tasty drink. With this fortified formula of spray dried whole milk and skim milk, Gerilac provides a specifically designed economical preparation for the aged.

GERILAC

the pleasant complete nutritional supplement for the aged



BORDEN'S PRESCRIPTION PRODUCTS DIVISION 350 Madison Avenue, New York 17, N. Y.

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PROTEINS...

Pre- and Post-operative



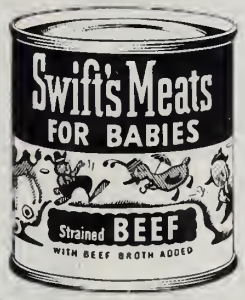
"Surgical patients in many instances tend to come to operations in a depleted state. There are many reasons for this: chronic gastro-intestinal disease . . . long-standing infectious processes . . . or loss of blood. The preparation of the patient for surgery includes nutritional preparedness. In the first instance, this means a good supply of *proteins* and carbohydrates.

"The operation itself and the reaction of the body to it in the immediate convalescent period are likely to increase breakdown of body protein. There seems little doubt that the recent stress upon maintenance and supplementation of dietary protein has had a beneficial effect upon the period of convalescence and the incidence of complications."*

SWIFT'S STRAINED MEATS

Palatable protein supplementation for patients on soft, smooth diets

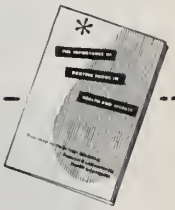
When surgery or disease creates a problem in protein supplementation, many physicians now use Swift's Strained Meats. These all-meat products provide an abundant and palatable source of complete, high-quality proteins, B vitamins and minerals. Originally developed for infant feeding, the meats are strained fine—may easily be used in tube-feeding or for oral feeding in soft diets. Swift's Strained Meats are convenient to use—ready to heat and serve. Six kinds provide variety and tempting flavors that help combat anorexia: beef, lamb, pork, veal, liver and heart. 3½ ounces per tin.



*"*The Importance of Protein Foods in Health and Disease*"—new, physicians' handbook on protein-feeding. Prepared by a physician, in conjunction with the Nutrition Division of Swift & Company, this booklet will be sent you free on request. Simply fill out the coupon.*

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Post-Infectious Recovery

Following recovery from severe infectious disease, acute nutritional deficiencies must be corrected promptly if maximum speed of recovery is to be attained. The nutrient imbalance which exists during this period usually involves not only members of the vitamin B complex, but also proteins as well.

The delicious food drink made by mixing Ovaltine with milk is a pleasant and effective means of increasing the intake of virtually all essential nutrients. Easily digested and of low curd tension, it does not impose an undue digestive burden, and is frequently acceptable when other foods are refused. Three glassfuls daily supply significant amounts of B complex and other vitamins including ascorbic acid, biologically adequate protein, readily digested fat and carbohydrate, and the important minerals copper, iron, and calcium. This dietary supplement is enjoyed by all patients, young and old, and is taken without difficulty in recommended amounts. Hence it might well be included routinely in the dietary of convalescence.

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CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on overoge reported volues for milk.

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MAKES TAKING A BASAL PLEASANT

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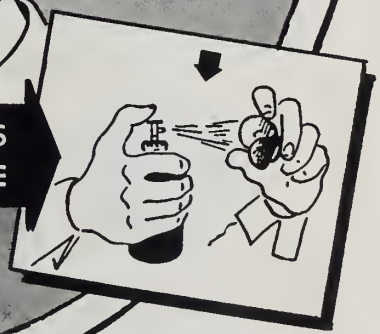


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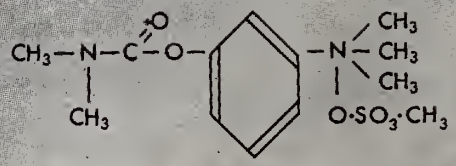
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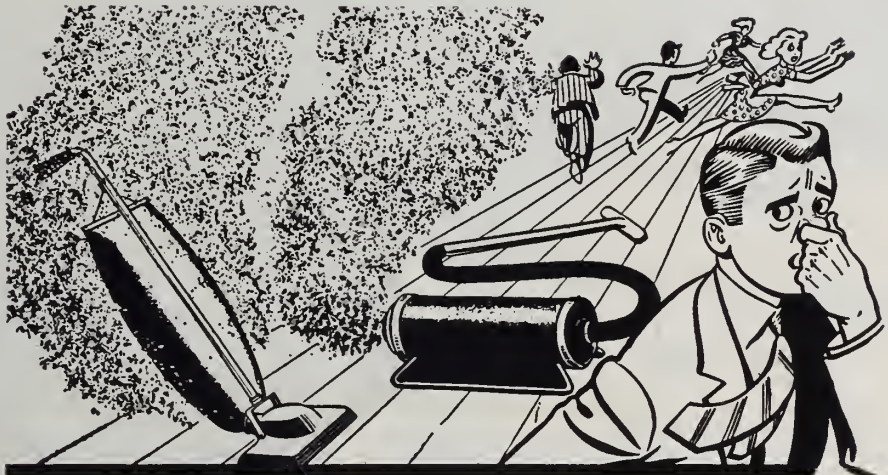


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*Reg. U. S Pat. Off. Prastigmin has became official in the U. S. P. XII under the name of neostigmine.

HOFFMANN - LA ROCHE, INC., ROCHE PARK, NUTLEY 10, N. J.



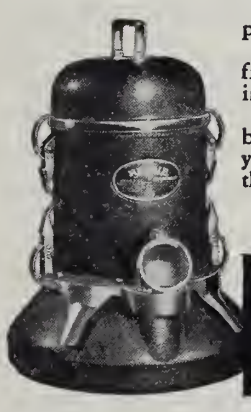
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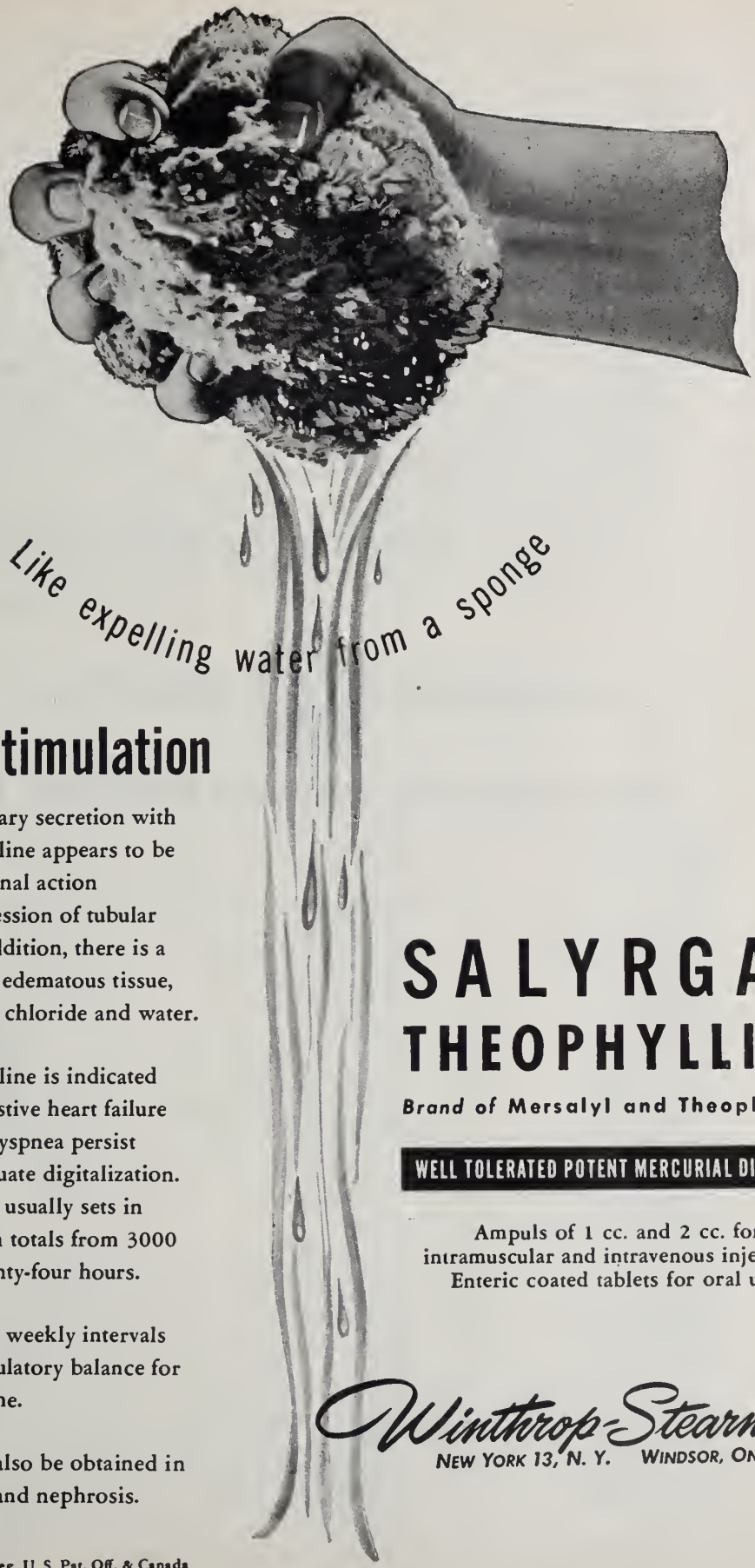
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Stimulation of urinary secretion with Salyrgan-Theophylline appears to be due chiefly to its renal action consisting of depression of tubular reabsorption. In addition, there is a direct influence on edematous tissue, mobilizing sodium chloride and water.

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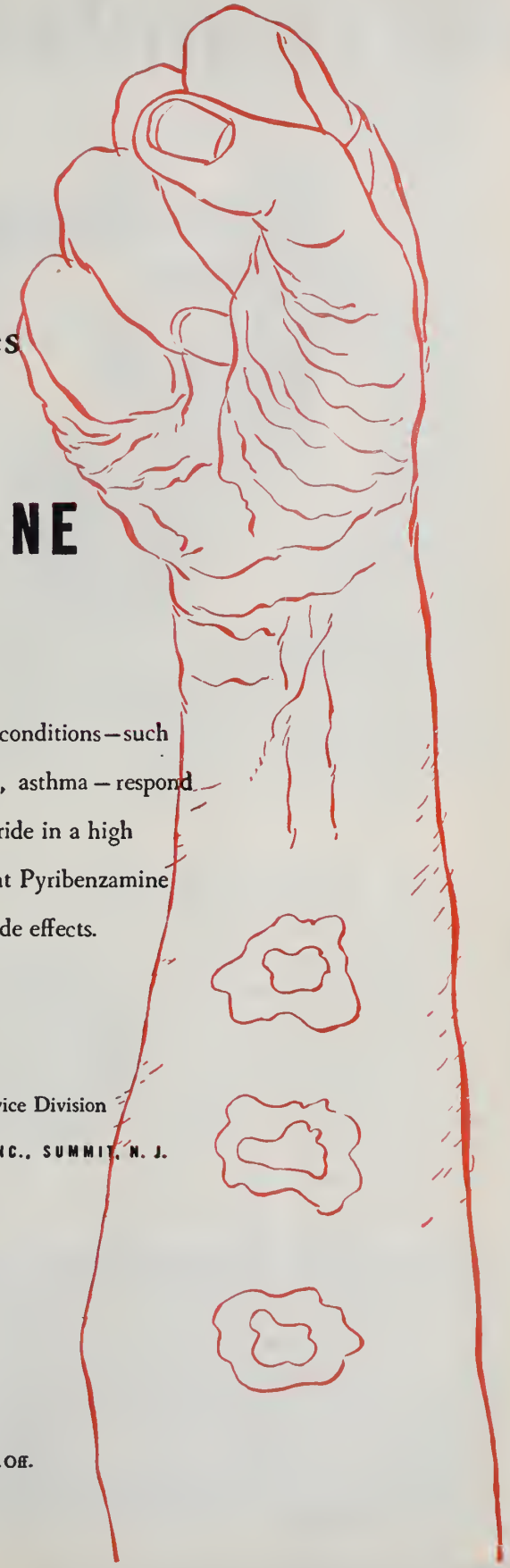
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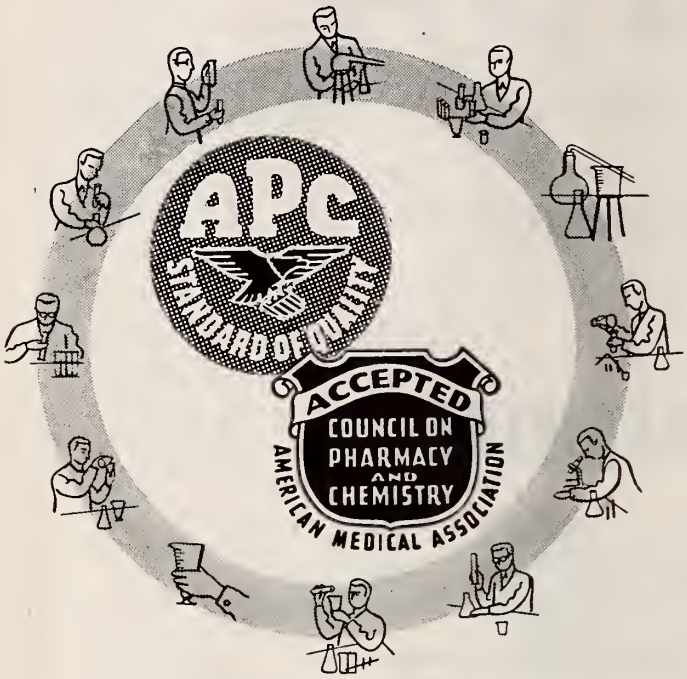


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Nestlé's is proud of the contribution it has made to progress in infant feeding; with each advance in scientific knowledge, it has made



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Nestlé's accepts milk only from carefully inspected herds. As further assurance of quality, rigid controls check Nestlé's Milk every step of the way. We even take the plant apart every day and wash it!

That's why so many doctors recommend NESTLÉ'S Milk

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PRENATAL SUPPORTS



Of the so-called minor complaints of pregnancy, a contributor to the medical literature* makes the following statement concerning backache —

"Backache seemed to be due to several causes. Strain of the lumbar muscles and the vertebral ligaments, due to a change in the center of gravity was often responsible; fallen arches aggravated the complaint. It was relieved by rest in bed. A maternity corset with moderately rigid stays in the back was of benefit . . . Sacro-iliac relaxation as evidenced by pain over the joint was usually unilateral and was referred along the sciatic nerve. Usually a maternity corset would relieve it. This corset should have a strap or other device that will pull it snug over the sacro-iliac region."

**Charles J. Marshall, New York Journal of Medicine, Vol. 34, Aug. 15, 1934*

Camp prenatal supports are unique in that the overstrap with its buckle (through which the lacings ply) allows the support to be drawn evenly and firmly about the pelvis; thus the pelvic joints are protected and steadied.

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A RECORD ANNUAL MEETING

With a record attendance of close to 2000 the 1948 Annual Meeting of The Medical Society of New Jersey passes into history, as one of the most interesting, inspiring and effective conventions that the Society has held in the 182 years of its existence. Never before have we had so many scientific sections—fourteen of them, each well attended and crammed with thought-provoking reports on medical progress. The award of a medal to Dr. Jacob S. Wolfe as the outstanding general practitioner in the state served as a symbol of the vitality of the family doctor, — the practitioner whose swan song has been often sung but whose requiem has fortunately always turned out to be premature.

The bestowal of honorary membership on Mr. William H. MacDonald of our State Department of Health was likewise an act of wide significance. It did honor to a man who has merited such honor by his contributions to public health and his constant cooperation with the medical practitioner. Beyond that it was a token of the cordial relationships between the official public health agency and the organized profession; a teamwork which, in New Jersey at least, has always meant progress towards better health for the people.

The House of Delegates transacted its business with dispatch but without loss of the debate and discussion, the meeting of mind with mind, which is the essence of the democratic process.

The scientific, technical and educational exhibits were eye-catching, instructive and well received. All this took place in the stimulating and refreshing environment of our Atlantic City, which continues to confirm its title of being not only the playground of the world, but also an ideal setting for the transaction of serious business and the recording of scientific progress.

ORIGINAL ARTICLES

CARCINOMA OF THE GALL BLADDER *
A REPORT OF 26 CASES

MAX DANZIS, M.D., Newark, N. J.

Primary carcinoma of the gall bladder was considered a rare disease in the early part of the last century. Occasionally a few sporadic cases were found at post-mortem examination and reported in the literature. However, during the latter half of the last century there was a continuous and progressive increase in the number of reported cases. At the beginning of this century there appeared several reports of a fairly large series of cases of carcinoma of the gall bladder in the American literature, notably those by W. J. Mayo, Moynihan, Judd, Deaver and others. With the development of modern methods of diagnosis and surgical treatment of gall bladder disease and the increased number of operations performed on that organ, came a corresponding increase in the number of reported cases.

The incidence of carcinoma of the gall bladder found at operations and necropsies varies between from 5 per cent as reported in the very early series of case reports, down to 0.5 per cent, reported in the recent literature. This reduction in incidence is ascribed by some to the fact that gall bladders are removed much earlier than in the previous years. However, one must bear in mind that the surgical reports are drawn from a selected group of cases. The actual incidence of this disease as tabulated from necropsies is much higher. Statistics drawn from a large and varied number of sources are much more reliable than those drawn from a small selected group.

This paper concerns itself with twenty-six cases of carcinoma of the gall bladder which were operated upon at Newark Beth Israel Hospital during a period of ten years, (1936 to 1946). Total number of gall bladder operations performed at that hospital during the same period (including both cholecystostomies and cholecystectomies) was 1645. Since 26 patients had primary carcinoma of the gall bladder, the ratio was 1.7 per cent. All patients were females, and all of these gall bladders contained stones.

These operations were performed by nine different surgeons. Two surgeons performed eight operations each. One surgeon did four. One did two. The remaining four operations were equally divided among four other surgeons.

Type of Operation	Number
Cholecystostomies	11
Cholecystectomies	14
Exploratory	1
	26

The youngest patient was 34 years old; the oldest, 76. Average age was 59. Twenty-five of these patients had no previous gall bladder operations. Only one was operated upon for gall stones and a cholecystostomy was done eighteen years previously.

Duration of illness varied between several days and thirty years. In sixteen cases, duration was one year; in one, it was two years. Two gave a history of between three and four years' duration. In the remaining seven, the history of gall bladder disease was present between a period of ten to thirty years.

I question the correctness of the history of several days' duration, which was given in one case. This patient was admitted to the hospital with a diagnosis of "acute abdominal condition". At operation, a perforation of the gall bladder was found, and there were stones in the gall bladder. The duration of illness in this case was doubtful. It is most likely that the patient had had mild attacks of pain previously (without causing serious physical embarrassment) which eventually culminated in acute perforation of the gall bladder which required admission to the hospital.

All the patients included in this group presented symptoms at one time or another of repeated attacks of colic, distention, belching,

* From the Surgical Service, Newark Beth Israel Hospital.

and bloating, and occasional attacks of nausea. Some gave a history of mild transient attacks of jaundice, nausea, and vomiting, lasting several days. Eight of the patients gave a history of definite jaundice, months or years before the operation.

I am impressed with the fact that all of them should have been relieved of their symptoms long before. Whether the malignancy of the gall bladder could have been obviated is hypothetical. However, in all these cases, stones were found in the gall bladder, and in some of them the duration of illness with a history of jaundice and repeated colic is of the utmost significance.

Stones were found in all our cases. In a review of 413 cases reported in the American literature during the same period by nine different authors, the presence of stones in carcinomatous gall bladder varied from 60 to 100 per cent with an average incidence of 76 per cent. One author reports a large series of cases in the foreign literature where the incidence of stones associated with carcinoma is 100 per cent.

Most authors are inclined to regard gall stones as an etiologic factor in gall bladder carcinoma. The frequency with which calculi are found in association with cancer of the gall bladder, and the experimental production of cancer of the gall bladder in animals by the insertion of foreign bodies into that organ, lead many to accept the theory that stones may be the prime factor in the production of this disease.

On the other hand a large number of capable clinicians and painstaking investigators believe that there is no direct relationship between the two conditions. One investigator (Harold Barrows) placed gall stones and other foreign bodies in the gall bladders of fifty guinea pigs who were kept alive as long as 399 days before they were sacrificed. Autopsy failed to reveal carcinoma in any of their gall bladders. These investigators conclude that chronic irritation is *not* the cause of gall bladder cancer. Some even believe that the stones so frequently found in carcinoma of the gall bladder are secondary to the pathologic process and are not the cause of it.

SEX RATIO

The ratio of male to female as tabulated from a report of 336 cases from the American literature is about four females to one male, a much lower ratio of females than in our series. An explanation of our high ratio may be found in the fact that the proportion of females to males in our entire gall bladder series is much higher than those given in other statistics. In a group of 250 cases reported by me several years ago, the ratio of male to female was one to nine.

PRE-OPERATIVE DIAGNOSIS

In not one of the 26 cases was the diagnosis of carcinoma of the gall bladder made upon admission to the hospital. This is not a reflection on the diagnostic ability of our surgeons. It merely shows that there are no definite criteria by which one may be guided in arriving at a diagnosis of early carcinoma of the gall bladder. It was rarely diagnosed preoperatively in a large series of cases reported in the literature. In cases where a preoperative diagnosis was made, the disease had already spread to the adjacent structures.

In our group the preoperative diagnosis was cholecystitis in six, intestinal obstruction in one, empyema of the gall bladder in two, acute appendicitis in one, carcinoma of the head of the pancreas in three (very close), and "large liver" in one. The pathologic diagnosis was carcinoma of the gall bladder in 24 cases, and carcinoma of the gall bladder with metastases to the common duct and liver in the two remaining cases.

MALIGNANCY DIAGNOSES AT TIME OF OPERATION

Cholecystectomies	5
Cholecystostomies	4
Exploratory	1

DIAGNOSED BY MICROSCOPIC EXAMINATION

Cholecystectomies	10
Cholecystostomies	6

In other words in 16 of the 26 cases (or 60 per cent), a diagnosis of malignancy was not made even during the operation, a fact of major significance. Evidently the disease was in its very early stage in some cases and the gross appearance of the gall bladder and its surrounding structures gave no reasonable suspicion of malignancy. In these cases, micro-

scopic examination showed definite malignancy. The presence of an acute inflammatory condition associated with the malignant process led to the operative diagnosis of acute cholecystitis and empyema of the gall bladder in two of our cases.

ASSOCIATED CONDITIONS

Associated conditions: In eight of these cases the condition was associated with disease of adjacent organs, which may be directly attributable to the primary gall bladder pathology. In one case, a stone had evidently perforated through a spontaneous cholecystduodenostomy, lodging finally in the ileum, causing intestinal obstruction. The obstruction was diagnosed before the operation. A perforation in the duodenum was also found. Death followed operation. Involvement of the cystic and common duct (which was disclosed at operation and thought to be inflammatory) was found in the second case. Microscopic diagnosis of the gall bladder was carcinoma. Involvement of the bile ducts with suspicion of carcinoma of the head of the pancreas was found in two cases. In one, there was beginning metastasis to the liver. A pericolicystic abscess (probably the result of a tiny gall bladder perforation) was found in another case, and a perforated gall bladder with generalized peritonitis was a complication in one of the cases. Metastatic carcinoma of the liver with involvement of the gastrocolic omentum was found in the eighth case.

POST-OPERATIVE END RESULTS

Died	8
Improved	13
Unimproved	2
Cured	3
	26

RESULTS

The eight immediate postoperative deaths included in the table above, were in patients who had extensive complications at the time of operation. In one case death followed after a prolonged postoperative septic course with chills, fever, jaundice and marked prostration. Thirteen patients who were discharged from the hospital are listed as improved. This is a most doubtful conclusion. While these patients showed evidence of immediate postoperative improvement, the eventual outcome was not taken into consideration when the notations were made on the patient's discharge. Two are recorded as unimproved upon discharge. Three are listed as "cured". It is self-evident that the word "cured" should be eliminated from the record.

In the thirteen patients who were listed as "improved" upon discharge and among the three listed as "cured", the diagnosis of carcinoma was not made either at the time of admission to the hospital or at the time of operation. The final diagnosis was made by our pathologist, Dr. William Antopol. These facts demonstrate the importance of a more careful checking of our operative records with the laboratory reports before final discharge forms are filled out.

There is no indication for doing a cholecystectomy in carcinoma of the gall bladder with evident metastasis to the liver nor where the extra-hepatic ducts are involved in the process. In three patients in this series such a procedure was carried out. There is no benefit, not even palliative, which a patient may derive from such a procedure.

FOLLOW-UP

The follow-up of the eighteen patients discharged as cured or improved was carried out through contact with their personal physicians or with the patients' families. Sixteen died within a few months or one year after leaving the hospital. One patient is alive almost five years after her operation. This is unusual.

This patient was admitted to the hospital with a diagnosis of cholecystitis of four days' duration. She had had attacks of upper abdominal pain off and on during the past eighteen years. Present onset was very acute. Operative diagnosis was empyema of the gall bladder with stones. Cholecystectomy was done. Microscopic examination showed infiltrating adeno-carcinoma and acute cholecystitis. Our pathologist rechecked the slides recently and assured me that the diagnosis of carcinoma is correct.

One patient who was operated upon six months ago is still alive. It is too soon to predict what the ultimate result will be. Since we can consider only one case as a "five-year cure", our proportion of cures in carcinoma of the gall bladder in this series is 4 per cent.

Surgical treatment of carcinoma of the gall bladder is discouraging. Only rarely may we hope for some form of palliative result. The accumulated experience of the reported cases including the small group here recorded shows that a diagnosis is usually not made preoperatively, and is frequently missed even at the time of operation, particularly in early cases.

Since in almost 80 per cent of the cases of carcinoma of the gall bladder, gall stones were present, one should look upon the early removal of gall stones not only as a means of freeing the patient from an annoying and painful affliction, but also as a prophylactic measure against cancer of the gall bladder.

The surgical risk of cholecystectomy in the well prepared and unjaundiced patients is gradually lessening. Mortality rate in cholecystectomy operations in the hands of experienced surgeons has gone down to 1.2 per cent. It is reasonable to anticipate that with progressive modern improvements in surgical technic and with the use of antibiotic drugs and other surgical supportive measures, cholecystectomy in uncomplicated cases may not yield any higher mortality results than a clean appendectomy.

CONCLUSIONS

1. Carcinoma of the gall bladder is an insidious disease, painless in its early stage. It cannot be diagnosed preoperatively at that stage.
2. In 60 per cent of our cases the diagnosis was not made even at the time of operation.
3. Malignancy should be suspected in a gall bladder if the walls are thick and friable or if the organ contains sharp stones.
4. Repeated attacks of gall bladder colic associated with acute and chronic cholecystitis justify surgical intervention.
5. Cholecystectomy in carcinoma of the gall bladder may save an occasional life provided the operation is done very early.
6. There is no justification for cholecystectomy in advanced cases where the disease involves the extra-hepatic ducts or adjacent organs.
7. If cholecystostomy is the operation of choice, a biopsy should be done.

31 Lincoln Park

ANTHRAX OF THE EYELID

EMILIE V. RUNDLETT, M.D., Jersey City, N. J.

Although, so far as I have been able to determine, no instance of anthrax of the eye or eyelid has ever been previously reported, our laboratory * has seen four such cases, all in workers employed by a rug factory. This factory receives its raw material from Persia and South America. The affected workers were wool sorters or washers. The case described below, is typical of the four. This patient was referred by Dr. H. S. Murphy of Roselle, N. J.

On February 4, 1948, the patient noticed a pustule on the left eyelid. He came to the Isolation Unit of the Jersey City Medical Center on February 8. A positive smear for anthrax was obtained. At the time of admission, swelling had completely closed the left eye. The lid was tense and fluctuant. Pus was oozing from it. The left side of the head and neck was swollen. The patient was disoriented, and his temperature was 105.6. A smear and culture were taken and a mouse was injected. The mouse died within twenty-four hours, and anthrax organisms were found in the animal's spleen. Encapsulated anthrax organisms were also found in the smear.

The patient received 200,000 units of penicillin every two hours for the next nine days. We also gave him twelve grams of sulfadiazine, and treated the lid with unguentum penicillin. He was discharged from the hospital on the fourteenth day. By that time he was able to open the eye. Only a slight eschar was present on the lid.

In this, as in the other three cases, there was a clinically perfect anthrax pustule, subsequently verified by laboratory findings.

* Laboratory of the Isolation Unit at the Jersey City Medical Center. Dr. Rundlett is Physician-in-Charge of this Unit.

79 Prospect Street

THE USE AND MISUSE OF HORMONES IN OBSTETRICS AND GYNECOLOGY *

A. E. RAKOFF, M.D., Philadelphia, Pa.

The sex-hormones are the most potent and specific medications which the obstetrician and gynecologist has at his command for the treatment of the functional disorders which arise in his specialty. Properly employed, they are valuable weapons in his therapeutic armamentarium. Improperly and indiscriminately used they will demonstrate their potency through many unfavorable reactions and may, indeed, do much to harm the condition of the patient and the reputation of the physician. It is only by vigorously opposing the injudicious use of hormones that their valuable assets can be preserved. It is not uncommon nowadays to hear over-enthusiastic reports of the use of the sex-hormones on the basis of ill-founded observations; and on the other hand, it is disconcerting to hear these preparations condemned for an evil not inherent in the hormones but in the injudicious use of these potent substances.

Proper endocrine therapy necessitates a correct diagnosis. In functional gynecologic disturbances this is frequently a painstaking task. Gone are the days when one could look at a fat amenorrheic woman and state with emphasis that "your trouble is pituitary". We have methods now which may demonstrate that her pituitary is not only active, but is perhaps producing excessive quantities of gonadotrophins. This can not be determined by clinical observation alone. Many stigmata formerly believed to be indicative of specific endocrinopathies are now recognized to be of constitutional origin.

Having made an etiologic diagnosis, the doctor must determine whether hormonal therapy is the rational method of approach even if he can demonstrate a pituitary or ovarian disturbance. The pituitary-ovarian cycle is a very labile one, influenced early in the onset of many organic diseases, dysfunctions, and metabolic disturbances and sensitive to neurogenic and psychogenic factors of all sorts. The physician who attempts to induce menstruation in a well-developed young woman with primary amenorrhea by administering estrogens for a long time is rightly embarrassed when it is later demonstrated that the patient has a congenital absence of the uterus and vagina which he failed to discover because no pelvic examination was made. Is this more lax than similarly treating an amenorrheic emaciated young girl who has unrecognized severe diabetes? Psychogenic traumata as a cause of sex-endocrine dysfunctions are particularly likely to be overlooked. They should be searched out diligently particularly in disorders which seem to have suddenly involved gonadotrophic function and ovarian response, not only because readjustment of the underlying problem is often the best mode of treatment, but because these patients often fail to make the expected response to hormonal therapy.

For many years thyroid was the only hormone considered worth using and practically all patients with functional disturbances of the reproductive organs were given thyroid whether or not they had hypothyroidism or alterations in metabolic rate. Empiric thyroid therapy did much good by "stirring up the glands". Just how this "stirring-up" works we do not understand, but to state that some patients were "stirred-up" in a manner not altogether favorable would not be an untruth. Today we have a large selection of potent hormones of all the endocrine glands. Choice of a sex-hormone should be made on a rational plan of approach. For instance a follicle-stimulating gonadotrophic hormone may be rationally indicated in anovulatory sterility where there is reason to believe that the pituitary production of gonadotrophin is inadequate. On the other hand gonadotrophic stimulation would be irrational in a similar patient who had all the evidences of a primary ovarian deficiency.

It must be admitted, however, that there are times when what may seem "irrational" ther-

* Read before the Section on Obstetrics and Gynecology, Annual Meeting of The Medical Society of New Jersey, April 23, 1947.

apy will accomplish the desired result. The point here is that the therapy works by an indirect mechanism which, if understood, can be better invoked. Thus, substitutional therapy with estrogens and progesterone may sometimes induce ovulation in a sterility patient if given in proper dosage and in cyclic fashion, on the basis of the "push-pull" mechanism which exists between pituitary and ovary. However, if estrogens are given continuously in high dosage, ovulation, even when it normally occurs, may be suppressed. This emphasizes another point in proper endocrine therapy: evaluation of dosage and timing. Many failures of endocrine therapy of functional menstrual disorders and sterility are the result of giving the proper hormones in inadequate dosage or at the improper time of the cycle, while untoward effects are frequently the result of excessive dosage or irregular administration.

Not all patients for whom certain hormones are rationally indicated are fit subjects for their administration. This point can be evaluated only by a familiarity with the untoward effects and over-dosage manifestations, as well as a knowledge of any conditions which may contraindicate their use. So far as the various specific types of hormores are concerned their main indications and the difficulties which may arise when they are improperly employed may be summarized as follows:

GONADOTROPHIC HORMONES

Follicle-stimulating gonadotrophic hormones find their chief use in the treatment of anovulatory sterility and some types of menstrual disorders caused by poor or irregular stimulation of the ovaries by the pituitary. Follicle-stimulating substances are available as pituitary gonadotrophins of sheep or horse origin or from the serum of the pregnant mare. When indicated, these substances are most safely employed during the first two weeks of each menstrual cycle followed by a rest period during the latter part of each cycle. *They should never be given continuously.* Even in amenorrheic patients they should be administered for two weeks followed by a rest period of equal length. Gonadotrophins prepared from sheep and horse pituitaries are less likely to provoke untoward reactions than those prepared from pregnant mare serum. During treatment the ovary should be carefully followed by frequent pelvic examination since cystic disease of the ovaries, abnormal ovarian enlargements or even ovarian hemorrhage may occur. These untoward effects are usually the result of prolonged therapy particularly if given throughout the cycle without adequate rest periods. Occasionally, however, they occur in patients receiving relatively small amounts particularly if some degree of follicular cystosis of the ovaries already exists. For this reason patients with enlarged ovaries are usually not good subjects for gonadotrophic therapy. Patients who develop ovarian enlargements after only a modest amount of treatment also are not likely to be benefited by gonadotrophins. Ordinarily, treatment with these substances should not be continued beyond three months without an equal rest period. Prolonged use of any of these gonadotrophic substances may result in the formation of antigonadotrophic antibodies which will neutralize the substance and defeat the treatment. Such anti-hormones may appear after three to six months of treatment with any of these substances. This often explains why patients with menstrual disorders which originally responded to gonadotrophic therapy relapse and fail to improve when therapy is resumed.

Since the gonadotrophic hormones are protein substances, local reactions following their injection are common and severe allergic reactions also occasionally occur. Allergic reactions are seen more often when pregnant mare serum gonadotrophin is used and may occur at the very first injection if the patient had been previously sensitized to horse serum. With the pituitary gonadotrophins, allergic reactions are more likely to occur after the patient has had several months of treatment and may come on abruptly. Patients should be skin tested (or conjunctival tested) before each injection, particularly with pregnant mare serum. This precaution is worthwhile but it must be remembered that reactions are sometimes seen in patients on whom such preliminary testing was negative.

Chorionic gonadotrophin is believed to exert

but little influence on the unstimulated ovary and there is even some question as to whether it is capable of bringing about luteinization of the partly stimulated follicle. Chorionic gonadotrophin when used in conjunction with a pituitary gonadotrophin or synergist has a very strong follicle-stimulating effect and has been used in this combination for this purpose. Chorionic gonadotrophin *per se* now finds its chief usefulness not in gynecology but in the treatment of suitable cases of cryptorchidism. Where chorionic gonadotrophin is used to stimulate better corpus luteum function it should be given in the last two weeks of the cycle. There need be but little worry as to side effects since it is relatively free from producing any serious untoward reactions or antibody formation.

PROLACTIN

Lactogenic hormone of the pituitary was at first used to treat inadequate lactation. This has been disappointing because poor lactation in the human is not often the result of lactogenic hormone deficiency but seems due to other factors such as constitutionally poor breasts, poor nursing regime, and the like. In occasional instances, prolactin in high dosage has proved worthwhile and deserves a therapeutic trial in selected cases.

More recently, the lactogenic hormone of the pituitary has been used for its luteotrophic effect on the theory that prolactin either directly stimulates the corpus luteum or acts as a synergist to the normal luteinizing factor. It has been recommended for dysfunctional uterine bleeding and appears to have a place in the management of some cases of this condition, although the mechanism by which it operates is not clearly established. In high dosage or over a prolonged period of time it may cause overstimulation of the breasts. It appears to be otherwise free from any serious untoward effects.

ESTROGENS

Estrogens are indicated chiefly in the treatment of primary ovarian deficiencies. In young women, estrogens may prove helpful in the treatment of amenorrhea, oligomenorrhea and hypomenorrhea. In small dosage, given in cyclic fashion, estrogens may sometimes cure associated sterility by regulating the pituitary-ovarian cycle. However, in large dosage, it can inhibit ovulation by inhibiting the pituitary. Indeed, it is sometimes used in the treatment of dysmenorrhea in this fashion since dysmenorrhea rarely occurs in the anovulatory cycle. For this purpose the estrogens are often used diagnostically, since if the resulting period is still painful there is strong reason to suspect that psychogenic factors are operating. Where this type of treatment is successful it is not generally wise to continue it beyond several months for fear of permanently inhibiting the pituitary and ovary.

The use of estrogens in high dosage for the treatment of hypermenorrhea is usually unwise and may give rise to further difficulties (especially in inexperienced hands). The bleeding which follows high dosage estrogen withdrawal is often more excessive and troublesome than the original state of affairs. In selected cases the administration of estrogen early in the cycle and estrogen and progesterone late in the cycle does give satisfactory results in the treatment of dysfunctional uterine bleeding but again it is not uncommon to see some patients develop even more profuse bleeding on this type of regime.

Estrogens are sometimes used for some specific effect such as to stimuate proliferation of the vaginal epithelium in treatment of gonococcal or atrophic vaginitis, inhibiting the lactogenic hormone for postpartum "drying up" of the breasts or inhibiting the gonadotrophic hormones of the pituitary. For the latter purpose, the estrogens are widely used in the treatment of the menopausal syndrome. In this condition the hormone should be employed with particular caution since it may result in uterine bleeding. This is the major obstacle to the use of estrogens in the treatment of the menopausal syndrome, since once bleeding has occurred it is impossible to know with complete assurance whether the bleeding is an estrogenic effect. In this way estrogens may conceal endometrial malignancy, if the bleeding is attributed to the hormone without further investigation by diagnostic curettage. Bleeding is much more likely to be encountered if the estrogens are given in ex-

cessive dosage or at irregular intervals or to patients who already have a history of menstrual irregularity.

Although estrogens are known to favor the appearance of cancer of the breast and cervix in certain laboratory animals, carcinogenic action in the human is, as yet, unproved. Estrogens in high dosage will produce endometrial hyperplasia. There is controversy as to whether such hyperplastic changes in the senile endometrium may be precancerous. There is reason to believe that if fibromyomata are present, their growth will be accelerated by estrogen therapy. For these reasons treatment with estrogens should never be undertaken until the patient has had an adequate pelvic examination indicating the absence of any such pelvic abnormalities. Nor should hormonal therapy be continued without frequent pelvic re-examination. There is ample justification for withholding estrogen therapy from any patient with a strong family history of pelvic or breast cancer. More discrimination is required in the indications for estrogen therapy and in selecting suitable cases.

In the obstetrical patient, estrogens in conjunction with progesterone are receiving increasing emphasis in the treatment of threatened and habitual abortion due to corpus luteum defect. The results with estrogen-progesterone therapy are more effective in the prevention of habitual abortion if therapy is instituted as soon as the patient becomes pregnant. In the treatment of spontaneous abortion, once bleeding has started the benefit of treatment is markedly diminished but appears to be better than with progesterone alone. Estrogen-progesterone therapy in the treatment of diabetes complicating pregnancy is now widely used particularly on the basis of the results quoted by Priscilla White and her group. For the present, it would seem wise to use this therapy as an adjunct, but not to substitute it for careful dietetic and insulin management of the pregnant diabetic woman.

Many natural and synthetic estrogens are available. Some of these possess specific advantages which make them more suitable for certain purposes but no one is ideal for all conditions and circumstances. Intolerance to estrogen therapy (causing nausea, headache, skin rashes or other symptoms) is more common with certain synthetic estrogens particularly the stilbene derivatives, but occasionally occurs with other estrogens. A synthetic estrogen which appears to be quite free of side effect is the hexadiene compound known as dienestrol. These side effects do not usually occur with the natural estrogens but may be seen with some of their synthetic derivatives, such as ethinyl estradiol. Frequently the symptoms are due to excessive dosage and can often be avoided by gradually increasing the estrogen dosage from a low level.

PROGESTERONE

With the high dosage preparations now available progesterone has become one of the most useful and safest hormones available for certain gynecologic and obstetric disorders. It is remarkably free from serious side effects and untoward reactions. In high dosage it is frequently effective in the treatment of functional amenorrhea resulting from either a pituitary or ovarian dysfunction. In similar instances of more protracted amenorrhea, the addition of estrogen as a priming agent is often necessary. Progesterone in high dosage appear to be far more effective than estrogen in maintaining normal cycling. It is believed to have a "back action" on the pituitary favoring the release of follicle-stimulating hormone in the next cycle and appears to make the ovary more responsive to endogenous gonadotrophic stimulation. For this reason it has a very valuable place in the treatment of the form of anovulatory sterility associated with a primary ovarian deficiency.

Progesterone for the treatment of dysmenorrhea and dysfunctional uterine bleeding is helpful in some instances, but its usefulness is distinctly limited. A common error in employing it is to give it through the entire cycle thus causing intermenstrual bleeding. Progesterone is best given in the last days of the cycle either from the time of ovulation to three days before the expected flow or (in higher dosage) later in the cycle. Progesterone withdrawal bleeding generally occurs three days after withdrawal. The practitioner should schedule its administration accordingly. An-

other common fault is the failure to give progesterone in sufficiently high dosage. To induce withdrawal bleeding a total 40 to 60 milligrams in three to five divided doses is frequently necessary. Ten milligrams of anhydrohydroxy-progesterone by mouth is equal to only two milligrams of progesterone by injection. If the hormone is to be given by mouth, five times the dosage is generally required. When progesterone is used during pregnancy, large doses are necessary and should be combined with generous amounts of estrogen to obtain maximum effect since these hormones have a synergistic and complementary action.

Progesterone rarely gives rise to unpleasant side effects. In sensitive individuals it may cause symptoms of marked premenstrual tension or bleeding. Itching of the skin at the site of injection is seen more often with progesterone than with any other steroid hormones. On occasion the site of a progesterone injection may become red and itchy at the time of each menstrual period for a number of months after the injection has been given. Some patients show a positive allergic skin reaction when tested against progesterone.

TESTOSTERONE

Androgens have a definite place in the treatment of gynecic disorders although their usefulness is limited by the frequency of unpleasant side reactions. Testosterone may be used to inhibit pituitary-ovarian function in some cases of functional uterine bleeding, mild cystic disease of the ovary, premenstrual tension and cystic mastitis. In using it for functional bleeding we have found it to work most effectively in primary ovarian deficiency, while it is less useful in gonadotrophic deficiency. Indeed, in the latter individual it will often temporarily cause an increase in bleeding. These patients do best on gonadotrophic therapy.

Testosterone may be used sometimes in the menopausal syndrome in cases in which estrogens are contraindicated, particularly because of the presence of fibroids or functional bleeding at the menopause. (If a good result can be obtained with a modest dosage of testosterone in a menopausal patient, this therapy is often safer and less worrisome than with estrogens.) In women, however, androgens can be used only in modest dosage and for only a limited period of time because they favor the appearance of arrhenomemitic symptoms, which usually develop in the following order: oiliness of the skin, acne, hypertrichosis, deepening of the voice and enlargement of the clitoris. Since only the first two of these symptoms are completely reversible, it is often necessary to stop treatment or reduce dosage when the skin has become oily or acne has appeared. Excessive increase in weight, partly due to water retention, is another common effect. Because of these side effects, androgen therapy in women should be (a) limited to conditions where a result can be expected promptly, or (b) used only as a temporary device to afford alleviation until more rational therapy can be instituted. The sensitivity of women to testosterone varies widely. The oft-quoted rule that not more than 300 milligrams of testosterone by injection should be given in any one month is good for general purposes but there are many patients, (particularly brunettes) who will notice untoward effects with considerably smaller doses.

The therapeutic effects and the side effects of testosterone are cumulative. As a rule less and less testosterone is required to keep the pituitary-ovarian cycle inhibited as treatment progresses, so that it is wise to keep reducing the dosage whenever possible. After an initial response has been obtained it is remarkable how little testosterone will be required for maintenance dosage. A very satisfactory effect can often be achieved by giving the hormone by mouth in the form of methyl testosterone. After an initial effect has been obtained many women will require only five milligrams of methyl testosterone daily for maintenance dosage during the last two weeks of the cycle for the relief of such conditions as premenstrual tension, cystic mastitis and hypermenorrhea. Care with dosage is the most important factor in the successful use of testosterone in women.

269 S. 19th Street

CLINICAL OBSERVATIONS ON SCABIES

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The return of military and navy personnel who had been abroad, has been coincidental with an appreciable increase in the number of cases of scabies. Scabies has never been entirely absent from local practice, but its recent resurgence has been conspicuous. The "itch", after all, is ubiquitous and in the past, entire hospitals have been set aside for the treatment of this infestation.

Patients are always eager to learn how this complaint has been contracted. We may generally dismiss suspected contacts, if the onset of the eruption followed within a few days after exposure to a suspected contact. This follows from the nature of the disturbance which is precipitated by the burrowing of a female adult *acarus* ready to deposit ova. Any such massive infestation from a contact must be exceedingly rare, and continued experience with this disturbance verifies this observation.

The latent period prior to the onset of clinical manifestation can be understood better when we are aware of the habits of the *acarus*. About forty days are needed for the full maturation of the female *acarus*. A patient initially infected with a few such mature *acari* would probably require several such cycles before appreciable clinical manifestation would be present. This is confirmed by repeated instances of clinical scabies in which the history of a contact extends back sixty to several hundred days. If no contact is discernible, the patient may report a gradual increase of itching with distinct intervals of intermission. We assume that intermitting intervals have been accompanied by a progressive increase of the infestation. Thus an extensive involvement, in which the extremities and thorax are involved may, curiously enough, evoke a very recent history of itching.

Itching may be minimal or even absent in generalized scabies. Also noteworthy is the frequent selectivity of a case, for a household with several members living in close contact may ultimately exhibit only one or two cases of scabies. The degree of itching, and the intensity of suffering accompanying this is as peculiarly individual as is the degree of infestation. Clinical improvement in the local findings is not always accompanied by cessation of the itching.

Isolated cases of scabies may elude diagnosis unless suspected, for the clinical appearance of this dermatosis can be very varied. Often, however, the clinical diagnosis can be made, or suspected, very quickly on general inspection at a distance. This is true in spite of the fact that it may resemble almost any kind of skin disease. If primary lesions are looked for, they can usually be found as pin point papules or linear lesions (pin point in width) shorter than a fine lanugo hair. From these early lesions almost any type of secondary involvement may eventuate, and these secondary factors are often diagnostically confusing. Pyoderma, impetiginized dermatitis and lichenified excoriated plaques are not uncommon.

Occasional diagnostic hints may be found in crusted itching papules on the buttocks or penis. Certainly the latter is almost always due to scabies if there is an itching dermatosis elsewhere of recent origin.

The usual lesions are in the webs and tender skin of the flexor surface of the wrist of anterior axilla and about the abdominal walls.

Recent therapeutic efforts, especially with emulsions, have met with the usual degree of success and failure. Relapses are not uncommon if ova are not destroyed, but a clinical sign of this may not be apparent until several cycles have passed. These are true relapses.

Snags which obstruct clinical improvement of scabies include occasional continuation of new lesions in spite of routine therapy, relapses (generally not more than once), persistence of itching after the disappearance of active lesions, and the patient's anxiety regarding the origin of the complaint.

Awareness of these complicating factors with assurance of the patient will, often enough, mitigate the problem.

11 High Street

CLINICAL EVALUATION OF LIVER FUNCTION TESTS

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The liver has remarkable regenerative power and reserve. Removal of a major portion of the liver in the experimental animal is followed by return to a normal physiologic unit in a relatively short period. It follows, therefore, that certain tests may be done too late to indicate damage, because regeneration of liver parenchyma may have occurred so rapidly as to invalidate a test or to mask the dysfunction of some remaining damaged tissue. A normal test response may result.

The liver may show no structural aberration, but physiologically it may be diseased. Thus, certain tests may appear abnormal despite an apparently normal appearing liver.

Jaundice on an obstructive basis, if long continued may result in secondary parenchymal damage causing an overlap of functional tests if done late in the course of disease. This overlap has done much to discredit certain tests. Actually, if liver physiology were understood, they would be viewed in proper perspective.

The liver by its complexity of and variety of functions may show disease in one component mechanism (such as its excretory mechanism) whereas it may be intact in another (such as its ability to convert vitamin K to prothrombin). Therefore, all or even a majority of the tests may not be positive in any one disease pattern.

No single liver test has been found which will enable us to pigeonhole or label any particular disease of the liver, nor to differentiate unequivocally the various types of jaundice, nor to uncover the approach of insidious disease. The gyrations of liver physiology are too varied for any one test to be all inclusive. This ebb and flow of disease, regeneration, and repair makes impossible any single magical diagnostic test. A variety of tests measuring a variety of functions, such as the metabolic, excretory, or detoxification processes of the liver must be done and their results evaluated.

Tests have been grouped by Tumen[1] as follows:

I. Test Based on Bilirubin Metabolism:
- (1) Van den Bergh—qualitative and quantitative
- (2) Icteric index
- (3) Bilirubin tolerance test
- (4) Urobilinogen—urine and stool

II. Dye Excretion Test—Foreign substance handled by the liver:
- (1) Bromsulphalein test

III. Test Based on the Liver in Carbohydrate Metabolism:
- (1) Galactose test—intravenous and oral

IV. Tests Based on the Liver in Protein Metabolism:
- (1) Total protein with albumin and globulin ratio
- (2) Amino acid tolerance
- (3) Takata Ara test
- (4) Colloidal gold
- (5) Blood prothrombin and response to vitamin K
- (6) Cephalin cholesterol flocculation tests
- (7) Thymol turbidity and flocculation tests

V. Tests Based on the Liver in Lipoid Metabolism:
- (1) Total cholesterol
- (2) Cholesterol ester and cholesterol ratio

VI. Detoxification Function of the Liver:
- (1) Hippuric acid synthesis

VII. Miscellaneous:
- (1) Phosphatase

Here then is the equipment with which we attempt to unravel the mystery of liver disease. Some of the tests fill a definite position in an abyss of liver disease, whereas others are limited in their usage by the very nature of the function they are measuring. To illustrate: determination of a dye excretion of the liver, (such as the bromsulphalein test) in the presence of deep jaundice would be inexpedient because the dye (being excreted in the bile) would be retained whether obstruction or hepatocellular damage were responsible for the condition. In certain other states, in the absence of jaundice, where hemorrhage or ascites is present, this test is of prime importance.

Before we can appraise these tests, we must determine what information we are seeking.

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1. Tumen, H. J.: in Bockus, *Gastro-Enterology*. Reference No. 2.

Certain of these tests have value in the causation of jaundice. We must know what information is desired. With this in mind we can discuss what assistance the individual tests can give in solving specific problems of hepatobiliary disease. We group our desired knowledge as follows:

I. Tests should aid us in the recognizing of occult liver disease.
II. Tests should supply information on the detection of residual liver damage or continued activity of hepatic disease.
III. Tests should serve in the differential diagnosis of jaundice.
IV. Tests should serve in the differential diagnosis of potential liver disease.

In the recognition of hidden liver disease, sensitive tests are of the greatest importance. The more refined the test, the more the likelihood of uncovering parenchymal damage. It is here also that a few tests measuring different physiologic aspects come into play.

TESTS OF VALUE IN OCCULT LIVER DISEASE
1. Bromsulphalein
2. Van den Bergh
3. Urobilinogen
4. Cephalin flocculation
5. Thymol turbidity
6. Hippuric acid

Bockus[2] uses as a routine: (a) the bromsulphalein, (b) uribilinogen, (c) Van den Bergh tests for suspected disease in the absence of frank jaundice. To these may be added the cephalin flocculation, thymol turbidity, and hippuric acid test. This combination measures the ability of the liver to excrete foreign dyes, its part in the metabolism of bilirubin, its ability to synthesize and detoxify certain products, and its probable aberration in protein metabolism. We have grouped here a variety of tests technically feasible and clinically sensitive enough to be capable of determining latent liver disease. We use two milligrams of bromsulphalein per kilogram of body weight and take a thirty minute zero end point as a routine. Mateer[3] by the use of five milligrams per kilogram of body weight and a thirty minute 0-5 end point has increased the sensitivity of the test. Others plotting a curve with removal of five minute specimens of blood have added another feature of sensitivity. However, since the thymol turbidity and cephalin flocculation tests are extremely sensitive, it may be advisable to keep the bromsulphalein less sensitive for correlation of graduation of liver damage. Hence we have continued to use the two milligram dose with a zero end point in 30 minutes.

Not all of these tests will give positive results. Confirmatory evidence from others in the group is advisable. The urinary urobilinogen, especially if repeated in afternoon specimens of fresh urine may detect some abnormality. Also in this category, should be included the Van den Bergh with its new refinements and photoelectric determinations to uncover latent jaundice. Both the cephalin flocculation and thymol tests are easy to perform, extremely sensitive, and complement each other. The hippuric acid test in the absence of renal disease (a blood urea or urea clearance test is often advised in conjunction with it) measures two functions of the liver in one test. It indexes the ability of the liver to synthesize glycine and detoxify benzoic acid and therefore is an extremely valuable adjunct. Should all or the majority of these tests be negative, no gross liver disease is present.

Certain of these tests are of value in detecting disease of Group II, that is residual liver damage, or continued activity of disease in the liver. Tests which may be of value in uncovering minimal damage may be unsuited for following the desiderata of disease or continued parenchymal activity. Whereas sensitivity in uncovering liver damage would be of importance in Group I, here the hepatic reserve must be measured. Just as in cardiac disease with heart failure, we measure the cardiac reserve by response to bed rest, then digitalis, and then the mercurial diuretics; or in the absence of failure, by the response of the heart to exercise, so can we employ liver function tests to determine hepatic reserve.

TESTS OF VALUE IN RESIDUAL OR CONTINUED LIVER DISEASE
1. Urobilinogen
2. Bromsulphalein
3. Bilirubin tolerance

2. Bockus, H. L.: *Gastro-Enterology*. Saunders, Philadelphia, 1946. Volume III.

3. Mateer, J. G.; Baltz, J. I.; Marion, D. F., and Macmillan, J. B.: Journal of the American Medical Association, 121:732, March 6, 1943.

4. Thymol turbidity and flocculation
5. Cephalin flocculation
6. Cholesterol and cholesterol esters

It has been said that the bilirubin tolerance test may detect liver damage for years after the active phase has subsided. The expense and technical difficulties nullify its advantages. However, thymol, cephalin and cholesterol tests may uncover smoldering low fire liver damage. A low cholesterol ester fraction, a 3-plus cephalin flocculation if persistent, or a positive thymol turbidity or flocculation, point to continued activity and suggest the necessity for further attention to treatment.

It is in Group III that the greatest emphasis in liver function tests has been placed, namely in the differential diagnosis of jaundice. Unfortunately, it is here that incorrect interpretation (because of lack of physiologic understanding of liver changes) has caused these tests to fall into disrepute. It is necessary to subdivide the group into early (within two to three weeks), and late phases of jaundice (over three weeks). The remarkable recovery phase or regeneration of liver cells in parenchymal damage may negate tests which should be positive, and the presence of persistent obstruction may produce secondary damage to liver cells and give results difficult to interpret from a diagnostic point of view.

TESTS OF VALUE IN JAUNDICE

1. Galactose
2. Hippuric acid
3. Phosphatase
4. Cholesterol and its esters
5. Thymol turbidity
6. Cephalin flocculation
7. Prothrombin time with response to vitamin K
8. Urobilinogen—fecal and urinary

These tests achieve their value from a "probability" standpoint, and an increasing probability in differential diagnosis is predicated upon an increasing number of these tests being corroborative. These tests may have as much value (and often more value) when they are negative than when they are positive. To illustrate: In the presence of deep early jaundice a negative cephalin test would be presumptive evidence of obstruction since it is rare to get a negative cephalin test in the presence of deep jaundice of parenchymal origin. A positive test here would be significant but less so since liver damage, secondary to obstruction may also produce a positive test. The cephalin flocculation test being so sensitive, would hardly be negative in the presence of diffuse liver cell damage. Therefore, a negative test in the presence of deep jaundice would fall high on the probability curve for obstruction. In the same light, a negative hippuric acid test in the presence of deep jaundice would probably indicate obstruction, whereas a positive test would be less significant since the liver damage secondary to obstruction may be picked up. However, early in jaundice, if both the hippuric acid and the cephalin flocculation were positive, the combination would strengthen the probability of the jaundice being hepatocellular. If both were negative in early deep jaundice, the probability of obstructive jaundice being present is greatly enhanced.

GALACTOSE TOLERANCE

A positive galactose tolerance test indicates liver cell damage almost at any stage of jaundice either early or late, for rarely has obstruction produced severe enough liver damage to give a positive galactose test. From a positive point of view, this test has great significance. If this test were negative, it could not exclude liver cell damage or support the diagnosis of obstructive jaundice. Regeneration may be rapid both during and after liver cell damage so that in the stage in which it was performed the test may be negative. Moreover, the damage may be too slight to give a positive test. In obstructive jaundice there is insufficient damage to liver cells to give a positive test even late in jaundice, (except in an occasional case). The galactose test therefore, falls high on the curve of probability of liver cell damage when positive, and loses its differential value when negative. With the use of an intravenous galactose procedure, Giansiracusa and Althausen [4] say that much more valid test would result. If mild jaundice (or jaundice of less than one week's duration) can be excluded they assert that three out of four cases of jaundice can be

4. Giansiracusa, J. E., and Althausen, T. L.: Journal of the American Medical Association, 129:589, June 14, 1947.

differentiated by this procedure alone and that 98 per cent of hepatocellular cases would be positive.

HIPPURIC ACID EXCRETION

The excretion test is also good if interpreted correctly. Here, however, a positive test is significant of liver cell damage if done early, whereas it would not be too meaningful if positive later in jaundice. The hippuric acid test may pick up secondary liver cell damage when obstruction has existed for some time. However, a negative test is of great significance in the realm of probability, for a negative test in deep jaundice suggests obstruction as the most likely causative factor. This is especially true in early jaundice but is somewhat valid even late in jaundice. A negative hippuric acid test in the presence of deep jaundice falls high on the probability curve favoring obstruction. With mild degrees of jaundice, if negative its value is decreased, whereas if positive its value is increased.

PHOSPHATASE TEST

The phosphatase test is a valuable procedure. It is usually positive in obstructive jaundice. It may be also elevated in parenchymal disease since only a small plugging of the intrahepatic biliary radicals will cause some elevation. But, a very high phosphatase bespeaks obstruction, usually complete, and more often that of neoplastic origin. When we uncover a negative test in the presence of deep jaundice this bears great significance, for such a result would point strongly to liver cell damage to account for the jaundice. On the probability curve it would rest high in favor of hepatocellular disease. With mild degrees of jaundice, the differentiation is decidedly less clear cut especially if the test should fall in the middle or low elevated range, that is, six to ten Bodansky units.

PROTHROMBIN TIME

Prothrombin time has been accepted by some workers as a test of value in the differential diagnosis of jaundice. Both obstruction and liver necrosis may lower the prothrombin level. In obstructive jaundice, if vitamin K is supplied, a lowered prothrombin should return to normal within twenty-four to forty-eight hours, whereas, in liver cell damage this does not occur or does so only slowly. Cholangitis with fever or biliary cirrhosis secondary to obstruction may negate the test and result in a failure of the prothrombin time to return to normal in obstructive jaundice. If liver cell damage is mild, the prothrombin time may be normal. In some states of liver cell damage this function of the liver may not be disturbed. In deep jaundice, if the response to injected vitamin K were prompt and sufficiently high it would point strongly to obstruction as its cause. A response of more than 20 per cent and an original prothrombin level of less than 70 per cent of normal is necessary.

CHOLESTEROL AND ESTERS

Within certain limitations and with an appreciation of the technical difficulties involved, this procedure has some noteworthy differential diagnostic value. Early in obstruction, the total cholesterol is elevated with a comparable normal ester ratio. Should the total cholesterol be normal or low in marked hyperbilirubinemia, the likelihood of obstructive jaundice being present is lessened. Nonetheless, as Tumen[5] has stated, cachexia and ascending biliary infection may lower the cholesterol value even in obstruction. Regarding the ester fraction, its interpretation in differential diagnosis is somewhat nullified because of its labile response. In hepatocellular damage where it is low and in obstructive jaundice with secondary parenchymal changes where it may also be low it would be of no service. However, in the presence of deep jaundice, if the ester ratio were normal it would point significantly to obstruction as the probable cause for jaundice. Here again, on the probability curve, the test would be significant, if positive, whereas if negative it would lose its differential value.

THYMOL AND CEPHALIN

Thymol turbidity and cephalin flocculation tests have been grouped together since they tend to parallel and corroborate each other. They probably both measure some aberration in protein metabolism. The thymol turbidity test as well as its modified thymol flocculation

5. Tumen, H. J., and Bockus, H. L.: American Journal of the Medical Sciences, 139:786, June 1937.

test bear similar significance. In the presence of deep jaundice a negative flocculation test strongly favors obstruction as the etiologic mechanism. This test is positive in diffuse liver damage and negative early in obstruction. Should secondary liver cell damage be superimposed in obstruction, this test would give a positive reaction. Again we see on the probability curve therefore, that when hyperbilirubinemia occurs, a positive test is of less differential diagnostic significance than a negative test.

UROBILINOGEN

A persistently absent fecal urobilinogen is a strong point in favor of obstructive jaundice and more nearly reflects the obstruction of neoplastic disease. Both stone obstruction and parenchymal liver damage rarely have persistent absence of fecal and urinary urobilinogen. To be valid this test must be repeated, and if the crude Wallace-Diamond technic [6] is employed, fresh afternoon specimens of urine are desirable.

By following the laws of probability and seen from the background of their physiological activity of the liver, these tests can be definitely interpreted to serve in the differential diagnosis of jaundice. The truism of early testing and repeated testing assumes paramount importance and even in relatively late jaundice their value is not completely nullified.

Besides helping in the differential diagnosis of jaundice these tests are of service in still other ways. They may be exceedingly useful in the differential diagnosis of potential liver disease. Here we are dealing chiefly with ascites and hematemesis both of which may be of liver origin or arise from a multiplicity of other diseases. Since ascites or hemorrhage are major signs of advanced liver disease (such as seen in cirrhosis) and since they usually occur with advanced liver dysfunction, we can see that our tests should show some aberration from the normal. Tumen,[7] as well as others, goes so far as to state that in patients with these signs or symptoms, normal liver function tests exclude cirrhosis as the cause.

DIFFERENTIAL DIAGNOSIS OF POTENTIAL LIVER DISEASE

1. Urobilinogen
2. Cephalin flocculation
3. Thymol turbidity
4. Hippuric acid
5. Serum albumin and globulin
6. Bromsulphalein

Of these, the last is of great importance. Many feel that a normal bromsulphalein test in the face of ascites or hemorrhage excludes cirrhosis as the cause. In my experience, that appears to be true. It has also been stated that repeated urinary urobilinogen determination of freshly voided afternoon specimens will be abnormally increased in almost all cases of cirrhosis or chronic hepatitis. Likewise, as Tumen [7] and Bockus [2] have shown, in the majority cases of cirrhosis the serum albumin will be lowered when ascites is present. If normal, then the diagnosis of cirrhosis should be viewed with suspicion. The cephalin flocculation, hippuric acid and thymol turbidity tests may also be positive here, but if these tests are negative they do not invalidate the diagnosis of cirrhosis. Should the bromsulphalein, urobilinogen, and protein determinations be negative, then it would be more difficult to accept cirrhosis as the cause for hemorrhage or ascites.

I have avoided any consideration of hemolytic jaundice because this can be clearly separated from the others by recourse to other diagnostic procedures. Even with the development of pigment stones and secondary obstruction, the positiveness of tests pointing to hemolysis are sufficiently accurate to occasion no great concern.

Instead of endless searching for the one liver test or for more sensitive tests that would give the "open sesame" to diagnosis in jaundice, it may be more feasible to reflect and digest the information we have learned already. By a proper selection of these tests and by employing a group of them measuring a variety of different liver functions we can do much towards solving the enigma of liver disease.

6. Wallace, C. B., and Diamond, J. S.: Archives of Internal Medicine, 35:698, June 1935.

7. Tumen, H. J.: Northwestern Medicine, 40:437, December 1941.

31 Lincoln Park

WHAT IS THE CAUSE OF CONGENITAL MALFORMATIONS?*

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Every obstetrician and pediatrician is frequently faced with the problem of the congenitally malformed child. These malformations vary from a comparatively minor defect like polydactylism to the more serious forms such as cerebral agenesis and congenital heart disease. The doctor generally is unable to offer any satisfactory answer to questions about the cause of the deformity, the chances of a similar or different deformity occurring in a subsequent pregnancy, or ways of preventing such defects. In recent years interest has been aroused by recognition of the relationship between certain infectious diseases, especially German measles, in the mother in the early months of pregnancy and the occurrence of congenital cataracts, congenital heart disease, and mental retardation in their offspring. This discovery, originating in Australia, has stimulated further investigations which, although admittedly they only scratch the surface, point the way hopefully to further discoveries.

INCIDENCE OF CONGENITAL MALFORMATIONS

Murphy[1] made an exhaustive study of the occurrence of congenital defects among the population of Philadelphia for the five year period ending in 1933, and found that among 130,132 consecutive certificates for deaths and stillbirths there were 890 confirmed instances of congenital defects; an incidence of 68 per ten thousand. Among the live born, 54 per ten thousand were defective; among the stillborn, 297 per ten thousand; indicating that malformations were five times more frequent among the stillborn than in the live born.

A study was made of 501 mothers who already had one deformed child. Of these, 226 had no further pregnancies, whereas 275, or 55 per cent, each had one or more later offspring, making a total of 431 conceptions. There were 43 deformed offspring among these 431 conceptions, an incidence of 10 per cent. Since there were 42 miscarriages where the fetal development was unknown, the true incidence was 43 deformed offspring among 383 live born children, or 1120 per ten thousand live births. Since the adjusted birth rate of defective persons in the general population was 47 per ten thousand of live births, the rate in families already having one defective child was 24 times greater! These figures furnish the physician with some exact data with which to answer the questions of parents who have one deformed child and who want to know the likelihood of producing more defective children.

Some information is also available as to the nature of the defect in the subsequent siblings. Is the defect in a later born sibling likely to resemble or be different from the first defect? A study of the types of defects seen in forty consecutive families each having two or more malformed offspring throws light on this subject. In 23 or 57 per cent the defect repeated once (i.e. occurred twice) and in two of the 23 the defect repeated twice—spina bifida and congenital hypertrophic pyloric stenosis. In 17 or 42 per cent of the families, two or more non-repeating defects occurred. Therefore, where defects recur in the same family, there is about a fifty-fifty chance of the same defect repeating. Incidentally, where malformations existed among distant relatives of a defective child, the defect was apt to be duplicated in nearly half the cases.

CLINICAL DATA

During the years 1939 to 1941 an epidemic of rubella (German measles) occurred in Australia. Gregg[2] reported 78 cases of congenital cataracts in infants of which sixteen were unilateral, including ten cases of microphthalmia and 44 of congenital heart disease. All were mentally retarded. *The mothers of all 78 children had had rubella in the early months of pregnancy.* Soon afterward Swan[3] reported the result of a survey made by the National Health and Medical Research Council. Of 61 cases of maternal rubella in pregnancy, 41 offspring had congenital malformations. In the case of the twenty normal infants, the rubella occurred late in pregnancy. The dividing line appeared to be about the beginning of the fourth month. The congenital malformations included deaf mutism, heart lesions, bilateral cataracts, microcephaly, obliteration of the bile duct and hypospadias. After reviewing his data, Swan concluded that "when a woman contracts rubella within the first two months of pregnancy, it would appear the chances of her giving birth to a congenitally defective child are in the region of 100 per cent, and if she contracts rubella in the third month, they are about 50 per cent."

* Read at the 643rd Meeting of the Orange Mountain Medical Society, South Orange, N. J., September 19, 1947.

1. Murphy, Douglas P.: *Congenital Malformations*, University of Pennsylvania Press, Philadelphia, Pa. (1939).
2. Gregg, N. M.: Tr. Ophth. Soc. Australia, 3:35 (1941).
3. Swan, C.; Tostevin, A. L.; Moore, B.; Mayo, H.; and Black, G. H. B.: M. J. Australia, 2:201 (Sept. 11) 1943.

Swan [4] reported a second series of cases two years later. Of 70 offspring of women with rubella in pregnancy, 49 showed congenital abnormalities. Twenty babies had eye defects; this included seventeen cases of cataract. There were 15 deaf mutes, and 26 infants who exhibited cardiac deformities. Swan had investigated carefully the correctness of the diagnosis of rubella in the mothers and concluded that no other diagnosis was tenable.

Following these reports, further articles confirming the findings were published in England by Sanderson [5] and Clayton-Jones,[6] and in America by Reese,[7] Erickson,[8] Albaugh,[9] Krause,[10] and Conte, McCammon and Christie.[11] Their data are summarized in Table I.

Fox and Bortin [13] searched the records of the Milwaukee Department of Health for all cases of rubella among young married women and then determined the number of congenital malformations occurring in their children. In three years there were reported 22,226 cases of rubella, 581 in married women. Of the latter, only 152 were available for investigation and eleven were pregnant; five up to the second month, four from the second to the fourth month, one in the seventh month, and one in the ninth month. Of the five mothers with rubella up to the second month, there was only one abnormal infant, a stillborn hydrocephalic child. One mother with rubella when six weeks pregnant had normal twins. There was one abnormality among the mothers with rubella between the second and the ninth month, a mild case of hydrocephalus which receded spontaneously leaving the child perfectly normal at two years of age. One mother with rubella in the second month gave birth to a normal infant, but eight years before had had a normal pregnancy resulting in a child with bilateral congenital cataracts. Thus out of eleven pregnant mothers with rubella, the incidence of congenital malformations was two or 18 per cent, a figure considerably at variance with Swan's.

TABLE I. RECENT PUBLICATIONS ON RUBELLA

Author	Year Reported	No. of Cases	Cataracts Microph-thalmus	Congenital Heart Lesions	Deaf Mutism	Micro-cephaly	Others
Gregg [2]	1941	78	78	44	0	0	
Swan [3]	1943	31	14	17	7	3	
Swan [4]	1944	12	2	4	5	0	Atresia of Bile Ducts
Reese [7]	1944	3	3	3	0	1	
Erickson [8]	1944	11	11	9	0	0	
Carruthers [12]	1945	18	0	1	18	3	
Albaugh [9]	1945	9	8	8	0	5	1 Pyloric Stenosis Undesc. Testes
Krause [10]	1945	5	4	3	0	0	3 Mental Retardation
Conte, McCammon and Christie [11]	1945	5	5	4	0	0	5 Mental Retardation
Sanderson [5]	1947	15	0	0	13	0	
Clayton-Jones [6]	1947	a 18 b123	Of 18 deaf children in one school, the mothers of 8 gave a history of rubella in 2nd to 4th month of pregnancy. Of 123 deaf children in another school, there were 11 cases of maternal rubella.				

EMBRYOLOGY

That certain embryologic changes are occurring in the fetus at the time the mother is affected with the rubella is probably more than coincidence. For instance, the forerunner of the lens of the eye appears as a thickening of the ectoderm over the developing optic cup at the fourth week.[14] The lens placode is then converted into the lens vesicle, which detaches from the ectoderm in the sixth week and loses its cavity by the eighth week. The

4. Swan, C.; Tostevin, A. L.; Mayo, H.; and Black, G. H. B.: M. J. Australia, 1:409 (May 6) 1944.
5. Sanderson, Robert: Brit. Med. Jour. 1:199 (Feb. 1) 1947.
6. Clayton-Jones, E.: Lancet, 1:56 (Jan. 11, 1947).
7. Reese, A. B.: Am. J. Ophth., 27:483 (May, 1944).
8. Erickson, C. A.: J. Pediat., 25:281 (Oct., 1944).
9. Albaugh, C. H.: Journ. Am. Med. Assn., 129:719 (Nov. 10, 1945).
10. Krause, A. C.: Annals of Surg., 122:1049 (Dec., 1945).
11. Conte, W. R.; McCammon, C. S., and Christie, Amos: Am. J. Dis. Child., 70:301 (Nov.-Dec. 1945).
12. Carruthers, D. G.: M. J. Australia, 1:315 (Mar. 31, 1945).
13. Fox, M. J., and Bortin, M. M.: Journ. Am. Med. Assn., 130:568 (Mar. 2, 1946).

lens, along with the other structures of the eyeball reaches its normal appearance during the third month.

The primordium of the internal ear appears from the ectoderm as the otic placode in the third to fourth week.[14] By invagination of the otic placode, the otocyst is formed, resulting in differentiation of the vestibular primordium and the cochlear primordium. The former eventually becomes the semicircular canals and the latter the cochlea. These changes occur during the fourth to eighth weeks. The morphology of the semicircular canals and the cochlea is complete early in the third month. During this same period the eighth cranial (auditory) nerve has been developing. In the fourth to fifth week the ganglia of the auditory nerve are formed from the neutral crest and become associated with the differentiating otocyst. Morphologic differentiation is essentially complete by the third month.

The heart in the fetus arises from two halves which secondarily unite. The embryonic heart of six weeks exhibits the general external shape and markings that characterize it permanently. The interventricular and interauricular septa develop rapidly, and by the seventh week the former is complete, although the latter is not entirely closed until shortly after birth.

EXPERIMENTAL DATA

Over the course of the past 35 years experimental work in animals has indicated with increasing certainty the relationship between deficient maternal diets and abnormal offspring. The experiments of Hart[15] and co-workers from 1911 to 1924 in the field of animal husbandry show an important connection between nutrition and reproduction. They noted that certain grain rations led to failure of reproduction or to the birth of premature, weak, or dead offspring. In later work it was shown that this reproductive failure was due to a lack of vitamin A in the rations used.

In 1931, Hale[15] at the Texas Agricultural and Experimental Station fed a gilt (a sow) a vitamin A deficient diet for five months before breeding and for one month afterwards, resulting in a litter of eleven pigs all born without eyeballs. The experiment was repeated with pigs: one had no estrus and was not bred; one failed to produce a litter due to early resorption of the fetuses; two others produced litters. One had to be given a single dose of cod liver oil two weeks before conception because she was so weak she could hardly stand due to the deficient diet; she produced a litter of fourteen pigs with various combinations of eye defects, some with no eyes, some with one eye, some with one large and one small eye, and all blind. The other sow produced ten pigs all without eyeballs. Genetic studies were carried out to determine whether hereditary factors were responsible for the eye abnormalities. Matings between blind brother and sister pigs, blind mother and son, and so on, *on adequate diets,* produced only normal offspring.

The most challenging experimental work has been done by Josef Warkany[16,17,18,19] and his co-workers. They fed female rats the Steenbock and Black deficient diet No. 2965. Up to the time of reporting, 761 young had been produced, of whom 517 or 68 per cent were normal and 244 or 32 per cent were abnormal. The abnormalities took the forms of shortness of the mandible, and shortness or absence of the radius, ulna, tibia, and fibula. The addition to the deficient diet of iron, manganese, casein, alfalfa leaf meal, and cod liver oil did *not* prevent deformities. If a female rat has had an abnormal litter while on a deficient diet, the succeeding litter will also be abnormal if continued on the diet. The addition of 2 per cent dried pig liver to such a deficient diet will regularly result in normal offspring. If the five separate constituents of the B-complex—(thiamin, niacin, pyridoxine, pantothenic acid, and riboflavin)—were added to the deficient diet together, normal offspring resulted, but together or separately the first four did not prevent. Riboflavin *alone* prevented the deformities.

By switching the female rats to the preventive diet (including 2 per cent dried pig liver) on consecutive days after conception, it was found that up to the thirteenth day abnormal offspring did not occur. After the fourteenth day, feeding the preventive diet did not afford complete protection against congenital deformities and abnormal offspring appeared. Therefore it appears that in female rats the period between the thirteenth and fifteenth days is the critical period in which the nutritional factor — apparently riboflavin — exerted its influence.

On the contrary, Warkany[18] found, if vitamin D is omitted and liver added to the deficient diet, a different type of deformity occurs. Half of the offspring showed marked curvature of the ulna, radius, tibia, fibula, and

14. Jordan, H. E., and Kindred, J. E.: *Textbook of Embryology,* New York, D. Appleton-Century Company (1942).
15. Cited in Editorial: Am. J. Dig. Dis., 11:12 (December, 1944).
16. Warkany, Josef; Nelson, Rose C.; and Schraffenberger, Elizabeth: Am. J. Dis. Child., 64:860 (Nov., 1942).
17. Warkany, Josef; Nelson, Rose C.; and Schraffenberger, Elizabeth: Am. J. Dis. Child., 65:882 (1943).
18. Warkany, Josef: J. Pediat., 25.476 (Dec., 1944).

a peculiar angulation of the ribs. If vitamin D was added, the malformations did not occur.

In another experiment Warkany [19] examined the head and face of 300 young born of mothers fed the Steenbock and Black deficient diet. Of these, 200 appeared externally normal and 100 abnormal about the head. Of the hundred, 44 showed cleft palate. The palates of 250 young born of females reared and bred on an adequate diet showed no abnormality. Also, the examination of the palates of a hundred young which were born of mothers bred on a deficient diet supplemented by dried pig liver showed no deformities.

Andersen [20] bred rats on a diet containing the minimum amount of vitamin A required for pregnancy and parturition. Since vitamin A produces a squamous type of epithelium in sites where it is normally columnar, it was thought possible there would develop defects of organs lined with epithelium, as for instance atresia of the intestine. This did not happen. Instead one-fourth of the rats developed a hernia of the diaphragm, usually on the right side. No mention was made of ocular defects in these animals.

It seems to be conclusively proved by these experiments that nutritional deficiencies can produce congenital malformations. But this does not *prove* that the lack of a nutritional factor plays a role in the cause of cleft palate in man.

RADIOTHERAPY AND IRRADIATION

Another factor that appears to produce defective offspring is irradiation. Attention was first called to this in 1929 by Murphy [21] who studied the outcome of 625 pregnancies in women subjected to pelvic radium and roentgen irradiation which resulted in only 74 full term pregnancies. Of these, defective children occurred in 25 cases, that is, 34 per cent. Defects included hydrocephalus, microcephalus, spina bifida, blindness, Mongolian idiocy, club foot and various structural malformations. Because of this high incidence, Murphy recommended that the pregnant uterus should never be subjected to irradiation, that diagnostic curettage should always precede pelvic radiotherapy to avoid irradiating an embryo, and that if, unknowingly, an embryo should be irradiated, the pregnancy should be terminated.

Jones and Neill [22] reported the results of a study of 56 cases of radium treatment of carcinoma of the cervix during pregnancy. Of these 56 children irradiated prenatally, 12 were living and normal, three years old or more. The authors contend that the presence of microcephaly, a common defect following irradiation of the embryo, cannot be ruled out definitely until the third year. There were 9 children who died of some unrelated illness before three years. There were three cases of microcephaly. The risk of an abnormal child following radiotherapy is therefore at the most, three out of fifteen determinate cases, or 20 per cent, or if the entire group is considered, three out of 52, or 6 per cent.

Irradiation should certainly not be applied until the fifth month because then the fetus is higher in the abdomen and the dangers from radium therapy less. This is substantiated by the authors' cases. Of three cases treated prior to five months, two were microcephalic. None of the five treated after the fifth month were abnormal in any way.

CLINICAL APPLICATION

As far as the nutritional and irradiation factors are concerned, prevention appears to be relatively simple and effective. It is essential that an adequate amount of riboflavin be included in the diet of the pregnant woman. This is accomplished most easily by administering one or two vitamin B complex capsules daily, although the diet of the average well-fed American woman usually includes sufficient riboflavin-containing foods to cover her daily requirements. Riboflavin is most commonly found in milk (15 to 20 ounces daily) and cheese, "enriched" bread, liver and dried brewer's yeast, peas, beans, eggs, and the green leaves of cabbage, spinach and watercress.

To prevent post-irradiation effects, the advice of Murphy [21] appears to be sound; that

19. Warkany, Josef, and Schraffenberger, Elizabeth: American Journal of Nutrition, 27:477 (June, 1944).
20. Andersen, Dorothy H.: Am. J. Dis. Child., 62:888 (Oct., 1941).
21. Murphy, Douglas P.: Am. J. Obs. & Gyn., 18:179 (Aug., 1929).
22. Jones, Howard W., Jr., and Neill, Wm. J., Jr.: Am. J. Obs. & Gyn., 47:447 (Oct., 1944).

is, to exert the utmost care *never to irradiate the pregnant uterus,* to precede pelvic radiotherapy wherever possible by diagnostic curettage. If, unknowingly, an embryo has been irradiated, terminate the pregnancy.

Since rubella confers an immunity to itself after one attack and is almost without complications in the non-pregnant female, prevention could be achieved by deliberately exposing all girls to German measles. In the opinion of the author, this entails negligible risk in girls five to fifteen years old. If the pregnant woman is aware of a definite exposure, the administration of five or ten cubic centimeters of gamma globulin intramuscularly in the early days of the incubation period would afford a temporary immunity. Stokes [23] cites the instance of a nurse who intimately exposed five room-mates with no history of the disease. No secondary cases followed the injection of gamma globulin in each of the contacts four days after exposure. In another study, an infant with rubella exposed all the children in a ward. Each child was given two cubic centimeters of gamma globulin four days after exposure and none developed the disease. Barenberg [24] reports the successful use of 30 cubic centimeters of pooled plasma or serum intramuscularly for the same purpose, but the ever-present possibility of transmitting homologous serum jaundice by this means lessens one's enthusiasm for it.

What should be done when the pregnant woman presents herself to her physician with rubella during the first three months? All the references in the literature except one indicate that the incidence of congenital defects following rubella in the first trimester varies from 50 per cent to 100 per cent. The one exception is the report of Fox and Bortin [13] from Milwaukee. A close reading of their report indicates two cases of hydrocephalus (one of which was apparently fortunate enough to enjoy a spontaneous cure!) out of six cases occurring in the first two months. With this rather impressive array of evidence, there is general agreement that a therapeutic abortion should be performed. It is cruel and inhuman to allow a pregnancy to proceed when the infant is so likely to be seriously malformed. The anguish suffered by parents of seriously deformed children should influence us to do everything that we possibly can to prevent such tragic consequences.

SUMMARY AND CONCLUSIONS

1. The adjusted incidence of congenital defects among the general population is 47 per ten thousand births. Congenital defects are five times more common among the stillborn than among the liveborn. If a family has one child with a congenital defect and then has more children, the chances of a defective child occurring subsequently are 24 times greater than among the population at large. The chances of the same defect recurring are about fifty-fifty.

2. Reports consistently indicate a relationship between rubella in the mother during the first three months of pregnancy and congenital malformations among the offspring, particularly congenital cataracts, microphthalmia, microcephaly, deaf mutism, and congenital heart disease.

3. Important embryologic changes occur in the fetus in the development of the eye, ear, and heart at the time the mother is affected with rubella.

4. Experiments show that if rats were fed on a diet deficient in vitamin B complex, their offspring regularly showed short mandibles and short or absent radii, ulnae, tibiae, and fibulae. The addition of 2 per cent dried pig liver to the diet prevented these deformities. The addition of riboflavin alone also prevented these malformations. The addition of the dried pig liver to the diet up to the thirteenth day after conception prevented abnormal offspring; after the fourteenth day it did not; therefore indicating that in rats the thirteenth, fourteenth and fifteenth days are the critical period for the possible development of malformed offspring.

5. The high incidence of deformed babies among mothers who received radium therapy or irradiation during pregnancy was shown.

6. For the prevention of malformations from these known causes, it is urged that wo-

23. Stokes, Joseph: Annals of Internal Medicine, 26:353 (March, 1947).
24. Barenberg, L.; Levy, W., and Greenstein, N.: American Journal of Diseases of Children, 63:1101 (June, 1942).

men receive adequate amounts of vitamin B complex (especially riboflavin) during pregnancy. It was recommended that the utmost care be exercised not to irradiate the pregnant uterus.

7. To prevent the disastrous after-effects of rubella during the first trimester of pregnancy, it is suggested that all girls between the ages of five and fifteen be deliberately exposed to rubella during an epidemic, thus preventing subsequent attacks. In the case of a known exposure to German Measles during the first three months of pregnancy, the intramuscular injection of ten cubic centimeters of immune globulin will probably prevent the occurrence of the disease. Where the clinical disease develops, a therapeutic abortion is indicated following recovery from the disease.

610 Park Avenue

FOLLICULAR LYMPHADENOPATHY

Chicago—A fairly common disease, seemingly benign in nature but which can develop into a true malignant condition, offers many challenging aspects to medical science, according to Erich M. Uhlmann, in a recent article in *Radiology*.

This disease is giant follicular lymphadenopathy, which bears a strong resemblance to Hodgkin's disease and is often mistaken for it. Uhlmann finds that giant follicular lymphadenopathy is more prevalent than most doctors suppose. After studying the clinical picture, he was able to diagnose the condition in nine patients within a six months' period. All of the patients had previously been under treatment for sarcoma, Hodgkin's disease, or leukemia.

The disease is characterized by either localized or generalized enlargement of the superficial lymph nodes. First enlargement usually occurs in lymph nodes of the neck. The correct diagnosis can be made if the pathologist is familiar with the microscopic findings.

While small amounts of x-ray radiation in most instances can produce disappearance of the involved lymph nodes, this does not mean cure of the disease. Roentgenologists should treat the disorder with large amounts of radiation, such as are commonly used in the treatment of cancerous lesions. Uhlmann tried this on several patients and found that they were free of symptoms for many years. Six of the twenty-two patients under his observation remained symptom-free for five years and longer, and others who have been followed for a shorter period may stay well for a similar time.

CONGENITAL DEFECTS AND GERMAN MEASLES

The web of proof that German measles during the first three months of pregnancy may cause congenital malformations is being woven tighter. Another strand in this web is the first report of the joint committee of the National Society for the Prevention of Blindness and the American Academy of Pediatrics.

In the report of 132 mothers who had German measles during the first trimester of pregnancy there were 18 babies reported as normal. Sixty-two babies weighed less than six pounds at birth. Seventy-six babies had congenital cataracts. Thirty-five were found to be deaf. Twenty-two were microcephalic and 46 mentally retarded. Malformations of the heart were diagnosed in 67 babies. Disturbances of the eye, other than congenital cataracts, were observed in thirteen, including congenital glaucoma, microphthalmus, nystagmus, chorioretinitis and strabismus. Dental defects were found in two children. Hypospadias was observed in four children and inguinal hernias in four. Malformations of the extremities were found in three babies. Cleft palate was diagnosed in three children and harelip in one. Micrognathia was found in one child. There was one cretin, one mongolian idiot, one with enlargement of an ear.

In order to make this study of increasing significance, the committee needs more case material, especially cases of German measles in expectant mothers *where the diagnosis has been made by a physician.*

Doctors who have such information are requested to write to Dr. Herbert C. Miller, University of Kansas Hospitals, Kansas City, Kansas, for a questionnaire.

STATE ACTIVITIES

OFFICIAL ATTENDANCE

182nd ANNUAL MEETING APRIL 26-29, 1948
HADDON HALL, ATLANTIC CITY

County	*Delegates*	*Members*	*Total*
Atlantic	10	65	75
Bergen	19	27	46
Burlington	7	23	30
Camden	17	62	79
Cape May	4	4	8
Cumberland	5	5	10
Essex	60	201	261
Gloucester	6	13	19
Hudson	27	42	69
Hunterdon	3	4	7
Mercer	15	52	67
Middlesex	12	51	63
Monmouth	7	57	64
Morris	11	20	31
Ocean	2	10	12
Passaic	26	37	63
Salem	4	2	6
Somerset	4	16	20
Sussex	2	1	3
Union	28	55	83
Warren	3	7	10
	272	754	1026
Visiting Physicians			73
Total Physician Registration			1099
Auxiliary			329
Visitors			298
Exhibitors			147
TOTAL REGISTRATION			1873

REGISTRATION RECORD 1934 - 1948

A record high registration, both physician and total, has been recorded for the 182nd annual meeting at Haddon Hall, Atlantic City, April 26-29, 1948. During the past fifteen years the attendance has been steadily on the upgrade, as noted in the official attendance records listed below:

Year	*Physician Registration*	*Total Registration*
1948	1,099	1,873
1947	772	1,374
1946	813	1,383
1945	(Meeting cancelled; Board of Trustees acted)	
1944	437	843
1943	(Abbreviated meeting, one and one-half days)	
1942	697	1,281
1941	747	1,387
1940	760	1,354
1939	851	1,606
1938	920	1,584
1937	696	1,308
1936	618	1,068
1935	365	873
1934	549	971

SCIENTIFIC EXHIBITS AWARDS

FOR MERITORIOUS INDIVIDUAL INVESTIGATION:

First Award:—Sarcoma Induced in Rats by Implantation of Cellophane.
B. S. Oppenheimer, M.D., E. T. Oppenheimer, M.D., A. P. Stout, M.D., New York City.

Second Award:—The Rh Factor and Erythroblastosis.
Philip Levine, M.D., Ortho Research Foundation, Raritan.

Third Award:—Substitution Transfusion Treatment of Erythroblastosis Fetalis.
Harry Wallerstein, M.D., Jewish Memorial Hospital, New York City.

FOR MERITORIOUS EXCELLENCE:

First Award:—Needle Biopsy of Liver.
Thomas J. White, M.D., Carroll M. Leevy, M.D., Angelo M. Gnassi, M.D., H. Preston Price, M.D., Medical Center, Jersey City.

Second Award: — Unipolar Electrocardiography, The Theory of Directions of Currents.
C. E. Kiessling, M.D., A. M. Lyle, M.D., H. B. Kirkland, M.D., Prudential Insurance Company, Newark.

Third Award:—Brucellosis.
Harold Harris, M.D., New York; Edwin H. Albano, M.D., Newark.

HONORABLE MENTION—Class I, Exhibits of Individual Investigations, judged on basis of originality and excellence of presentation:

Studies on Blood Platelets in Health and Disease.
Sylvan E. Moolten, M.D., Leo Vroman, St. Peter's Hospital, New Brunswick.

Class II, Exhibits which do not exemplify purely experimental studies, but which are judged on the basis of excellence of correlating facts and excellence of presentation. This award is limited to New Jersey exhibitors.

Sudden Death in Infancy, Thymico-Adrenal Syndrome.
Harrold A. Murray, M.D., Salvatore J. Rose, M.D., St. Michael's Hospital, Newark.

COUNCIL ON NATIONAL EMERGENCY MEDICAL SERVICE

REPORT OF APRIL 5, 1948 MEETING

A Council on Emergency Medical Service was established by the A.M.A. House of Delegates in June 1947. It held an organization meeting in December 1947 and since then has met in conference with Secretary of Defense Forrestal and with representatives of the National Security Resources Board. The Council has been assured by federal authorities that its services will be appreciated and will be used in an advisory capacity.

It is the opinion of the Council that the country does face a threatened emergency and that it is time for joint planning with federal authorities to effect a program for the best utilization of available personnel and facilities in case a national emergency does materialize. The Council believes that all planning and policy making regarding medical manpower and civil defense must be at a national level; but that detailed planning cannot be accomplished until the needs and policies of the armed forces are defined.

The Council has received replies from the governors of 37 states indicating that in 8 states there are already specific "State Disaster Plans"; in 8 states such plans are being developed, and in 13 states (including New Jersey) official committees have been appointed to develop plans. In 8 states no steps have been taken. Eleven states have not replied. It is significant that in no state so far reporting is any mention made of medical society representation on any state committee.

Secretary of Defense Forrestal has appointed, as a branch of his office, a "Civil Defense Board". This Board, composed of the Secretaries of the Army, Navy and Air Corps, is temporary in nature. As part of this Board is the "Committee on Civilian Components", headed by Mr. Russell Hoppley. It is the function of this committee to prepare an organization, including necessary legislation, for a permanent department of "Civil Defense Planning".

Included in the government's "organization for National Defense" are: (1) National Security Council, (2) National Security Resources Board and (3) Department of Civil Defense. (1) The National Security Council is purely military, a war cabinet, acting in an advisory capacity to the President. (2) The National Security Resources Board has the functions of mobilizing all of the material and personal resources of the country with which to prosecute a war. This agency will have to do with the mobilization of medical manpower and facilities and of their assignment to the military and civil defense program. (3) The Department of Civilian Defense will be a civilian organization to establish the policies and over-all planning of the civil defense program. It will develop the technics of defense and train men to operate and administer these technics.

The planning of a national civil defense program will require the services of full time physicians with the Department of Civil Defense assisted by a panel of medical advisers. The national pattern (adaptable to standardization at a local level) will be evolved by the Department of Civil Defense. We are warned not to get "out of line" with the policies and thinking of the Department of Civil Defense.

The army will look to the Council for a survey of medical personnel, both quantitatively and qualitatively; for determination of physical standards for military service, to the end that all medical requirements, both civil and military, may be properly balanced with available procurement.

The Army, during World War II, calculated its medical personnel requirements at the rate of 6 medical officers to each 1000 enlisted personnel. This in turn was based upon requirements of the type of warfare experienced in World War I. From experiences in World War II [and in consideration of the type of warfare anticipated in any future war] it is appreciated that military casualties will be much less than civilian casualties, that relatively fewer physicians will be required for the military and that a larger number must be made available for the care of civilians.

Should a national emergency occur, the Army and Navy will be too occupied in retaliation efforts to lend appreciable assistance in the civil defense program.

One Air Force speaker recommended that all physicians be examined and classified physically and each assigned to military or civilian duties; that those assigned to the military be allowed to remain in their private practices on an "alert" status until shortly before the need of their services is anticipated. This will be possible because of present rapid means of transportation to any point in the world.

The framework of the Selective Service organization still exists as the "Office of Selective Service Records". It took ten months during the last war for Selective Service to develop its maximum effort. Present planning should enable this agency to be prepared at the onset of a future emergency. Ninety per cent of local board members have ex-

pressed willingness to serve in a future emergency. It is recommended that a physician be appointed to each local board. Physician examiners will serve on the same status as in World War II and will be asked to donate their services. It is anticipated that the physical examination of selectees by local boards will be a complete examination and not a screening examination as in the latter part of World War II. A bill, introduced in the Senate a few days ago, provides for the establishment of a Selective Service Program covering all men between 18 and 45 years and for a National Training Program covering all men between 18 and 26 years. One significant provision of this bill is that providing for the induction of physicians.

During World War II, the military took 40 per cent of our physicians to serve 9 per cent of the population; yet the health status of the civilian population remained high. We have the highest physician-population ratio of any country in the world. As replacements for 4000 annual deaths we have 6000 new medical graduates each year. The armed forces have taken practically every recent graduate for a two-year tour of duty. About 15,000 veteran physicians are still taking graduate training. These men are not currently included in our physician-population ratio. Five new Class A medical schools have been placed in operation since the war. It is the opinion of the Council that we have sufficient physicians to meet the need of the military and civilian population in case of a national emergency.

The best source of information on atomic warfare, released by the government, will be found in the publication "Air Officers" for March 1947. The latest government publication on civilian defense is titled "A Study of Civil Defense" dated February 1948 which may be obtained from U. S. Printing Office for 8 cents.

The framework of our new civil defense organizations and program should be the same as that of World War II plus the addition of atomic defense.

We were shown movies of the silent, ghastly picture following the atomic explosions at Hiroshima and Nagasaki; a cataclysmic, complete destruction of all human beings and property in the area affected. Deaths, not by the dozens or the hundreds, but by the many thousands, with the delayed effects causing misery and later deaths of other thousands. And yet few people appreciate or understand the lethal effects of these neutrons, alpha, beta and gamma rays. It presents a hopeless picture as far as military defense is concerned.

The Council agrees with the recommendation of Mr. Forrestal, that physicians and laymen associated with the civil defense program be given special instruction and training in all aspects of atomic radiation.

There must be a "psychologic warfare" program to promote among the people a high morale and sense of responsibility to carry on under the most trying conditions. Good morale among the population will prevent panic and promote orderly action. We must prevent fear, confusion and demoralization by developing a proper psychology among the people. The medical profession must take a leading part in making such a program effective.

The "psychologic" program must reach the man in the street. It must use simple language. Probably the most effective step is the dissemination of basic information and advice through the press, supplemented by more detailed information and advice by radio.

Large quantities of blood and blood derivatives are a prime necessity. The Red Cross will assume responsibility of supplying blood in the quantities needed.

Palliative treatment, prevention of infection and nursing care must be given to thousands of survivors.

Contaminated persons must be screened from the general population. Radio-activity detectors, to be supplied by government will be necessary. In the Bikini tests any military persons showing a reaction equivalent to 1/10 roentgen unit was considered contaminated.

Extensive hospital facilities will be necessary for the care of survivors suffering from delayed action of radiation and for blood studies of all persons in the periphery of the affected area.

The problem is made more difficult by the contamination of water supplies and food supplies, by the difficulties of evacuation, and by the destruction of facilities and equipment. The disposal of the dead is a major public health problem. All problems are multiplied because of the danger of entering the stricken area for weeks following the incident.

It may be assumed that this Society will very shortly be requested to organize a State National Emergency Council. The development of the medical phase of a civilian defense program offers a major challenge. It is hoped that such a program will be organized on county rather than on a municipal basis as was done in World War II, and that it will be integrated at a state and inter-state level.

NORMAN M. SCOTT, M.D.

PROGRAM OF THE FIELD ARMY

American Cancer Society, New Jersey Division, Inc.

At the inception of the New Jersey Division, an agreement was reached between the laymen and the medical men. The division of responsibilities of the two groups was clearly defined as follows:

"It is the responsibility of the doctors to advise how, where and for what medical facilities, programs and services money shall be spent. It is the responsibility of the laymen to raise the money and to administer the funds in accordance with sound business practices."

This definition includes the Field Army, which is an integral part of the Cancer Society. The responsibility of the Field Army is the same as that of the County Chapter—of which the Field Army is a part.

In conducting the New Jersey Division's lay program the direct responsibility of the Field Army may be defined as follows:

"It is the responsibility of the members of the Field Army to conduct a service and education program within the counties, under the direction of the Board of Managers and executive committee of the county chapter. It is the responsibility of the Field Army to submit all programs to the chapter and to receive approval from both the chapter and the Advisory Cancer Committee of the county medical society. The Field Army will conduct its program in accordance with the policies of the Board of Trustees, New Jersey Division."

FUNCTION OF THE FIELD ARMY

To provide the volunteer organization needed to activate the education and lay service program of the county chapter.

To assist in the fund raising campaigns.

The Field Army program is divided into two major sections:

1. Lay service.
2. Education.

Each phase of the program represents a challenge to the volunteer workers of the American Cancer Society in New Jersey. Obviously, to conduct a comprehensive and active program, an organization of numerous workers—depending upon the population of the county—is needed. For that reason, the County Field Army Commander should function with a county chairman for education and a county chairman for lay service.

Efficient organization should include education and lay service chairmen in each of the county's communities. These chairmen should be directly responsible to the County Field Army Commander, who will report to the State Commander and to the Executive Committee of the county chapter.

THE LAY SERVICE PROGRAM

The lay service program is divided into the following categories:

1. Production of cancer dressings.
2. Transportation (Motor Corps).
3. Record-keeping, clerical (Staff Assistance).

CANCER DRESSINGS

A quarterly survey should be made in cooperation with local doctors, hospitals and welfare agencies to determine the needs in the county. The program should then be planned to fill the needs without producing a large oversupply at any time.

A central location should be selected as the receiving and disbursing point for all dressings.

The county lay service chairman should appoint individuals in each unit to be directly responsible for production. Select one or more well-trained persons to serve as instructors for new units. An inspector should be appointed to check dressings, in order that uniformity be attained and that dressings be produced that are acceptable to the hospitals and physicians which can be used with the greatest efficiency.

Dressings are produced from salvage materials and cellu-cotton.* The cellu cotton is purchased by the county chapter and for purposes of efficiency and economy can be ordered, with approval of the chapter president, through the State Service Department. Order blanks will be provided by the State Service Department. Estimate needs and order on a monthly basis.

Salvage materials can be secured by a public appeal through the press, radio and at group meetings. Only white and ironed materials can be used for dressings. When produced, dressings should be tied neatly in lots of 12, using strips from salvage material as ties.

A high standard is necessary. If dressings are not produced correctly, they will fail to provide the service needed by cancer patients.

In addition to dressings, units can produce bed serviettes, bed pads, gowns, scuffs, kit bags, etc. These articles can be produced at times when the supply of dressings has reached the quota found necessary in the county. An over-supply of dressings can be given to counties needing these supplies. Arrangements should be made through the State Service De-

*See leaflet "Cancer Dressings" published by American Cancer Society.

partment. The county receiving such supplies should pay for cost of cellu cotton and other purchased materials.

Unit chairmen should report monthly to the county commander, who will report production records to the state commander.

TRANSPORTATION

Volunteers of the Field Army can perform an important service through organization of a motor corps, planned to provide transportation for cancer patients from their homes to clinics and doctors' offices when no other means are available. The motor corps chairman should arrange schedules listing persons who are available on certain days of the week. Doctors, hospitals and welfare agencies should be asked to refer patients needing transportation to the motor corps when no other means are available.

This group can also handle the distribution of dressings and arrange to pick up produced dressings from the various units. Delivery of dressings to the hospitals or directly to the home of a cancer patient is the responsibility of this group.

STAFF ASSISTANTS

Where it is indicated and is approved by the county chapter, a headquarters can be staffed by volunteer members of the Field Army, who can assist in keeping records of the chapter, receiving requests for dressings, films and educational material and in compiling reports needed to evaluate the program from time to time.

Volunteers willing to serve in this group can be asked to devote one day, or part of a day, each week.

EDUCATION

The education program is of great importance. It should be a separate activity of the volunteer workers. Except in counties with very small population, the educational program should be conducted by groups of volunteers responsible for this program and not active in the lay service program.

The purpose of this program is:

1. To arouse the indifferent layman who does not know enough about cancer to be concerned.
2. To reassure the frightened layman who is so afraid of cancer that he doesn't even want to hear the word mentioned.
3. To reeducate the misinformed layman who may have an active, though misguided, interest in cancer.
4. To teach the interested layman.
5. To activate the informed layman.

BASIC FACTS

Basically, the education program is aimed to inform every layman that many cases of cancer can be cured if detected in time, and to make available to all the seven danger signs, which are:

1. Any sore that does not heal—particularly about the tongue, mouth or lips.
2. A painless lump or thickening, especially in the breast, lip or tongue.
3. Irregular bleeding or discharge from any natural body opening.
4. Progressive change in the color or size of a wart, mole or birthmark.
5. Persistent indigestion.
6. Persistent hoarseness, unexplained cough, or difficulty in swallowing.
7. Any change in the normal bowel habits.

EARLY DETECTION

In New Jersey, the keystone of the cancer detection program is the family doctor. More than 1600 New Jersey doctors have signified that they are ready and willing to conduct complete health maintenance examinations in their offices. When signs and symptoms indicate, the family doctor will refer the medically indigent patient to one of the 30 established cancer clinics in general hospitals, for laboratory workup and diagnosis. Indigent patients should report to the social service worker when they go directly to the hospital clinic for diagnosis.

This program has been arranged by The Medical Society of New Jersey in cooperation with the American Cancer Society, New Jersey Division, Inc., and the improvement and expansion of clinic services have been made possible through funds contributed to hospital clinics by the American Cancer Society.

To facilitate the family doctor's work, the New Jersey Division, in cooperation with The Medical Society, has sponsored a biopsy program. This embodies the taking of suspected tissue by the practitioner sending the tissue in a container supplied by the New Jersey Division, to a pathologist of the physician's choice, who makes the diagnosis. The pathologists have agreed to make such examinations at their regular fee for private patients but without charge for indigent patients unable to pay the usual charges. This program has expanded to place similar containers in dental surgeons' offices.

It is the responsibility of the education committee, as well as all members of the American Cancer Society, New Jersey Division, Inc., to urge the public to receive complete health maintenance examinations at least once a year—through the services made available by the general practitioners of the state.

"See Your Family Doctor" is the slogan to be kept uppermost at all times. Statistics prove

that the general practitioner sees more early cancer patients than all clinics.

The State Service Department and The Medical Society of New Jersey have published a booklet listing New Jersey doctors willing to conduct health maintenance examinations in their private offices. This booklet is available to those who request it.

THE MESSAGE

This then, is the message of education:

1. Cancer can be cured if detected in time.
2. Be aware of the seven danger signs.
3. See your doctor regularly for health maintenance examinations.
4. Cancer is not to be feared—but to be guarded against.
5. It is not a disgrace—it is a misfortune.

MEDIA

The message can be carried to the public through the following media:

1. Direct mail. Mailing of education leaflets to lists secured at county level.

2. Radio. Arrangements can be made for "spot" announcements, scheduled speeches by prominent doctors, prepared scripts and transcriptions all of which can be secured from the State Service Department.

3. Newspapers and periodicals. Mats, model stories and advice are available from the State Service Department. Educational releases are mailed to all New Jersey newspapers by the State Service Department and can be made available to committee chairmen on request.

4. Bus cards. Arrangements can be made for educational cards to be used gratis. These cards are available from the State Service Department.

5. Motion pictures. Several educational films are available. These can be borrowed from the State Service Department.

6. Exhibits. Arrangements are made by the State Service Department for exhibits at various state-wide conventions and meetings. Field Army volunteers are asked to staff these exhibits, distributing literature. Exhibits can be made available for county meetings.

7. Clubs and organizations. Arrangements should be made with service clubs, fraternal and veterans organizations to devote an occasional meeting to cancer. A speaker can be arranged, films shown and literature distributed. The Speakers Bureau at the State Service Department will assist.

8. Schools. Cancer education in grades lower than the high school is not recommended. Arrangements for special cancer programs or courses should be made through cooperation of county superintendents and local supervising principals. Special leaflets are available. In some schools, the cancer problem is discussed as part of the biology, science or hygiene courses. Attention can be attracted by stimulating essay contests through English departments of the high schools.

9. Nurses training schools. Cooperation can be given to nurses training schools in need of cancer literature and scheduling of professional speakers.

10. Libraries. A kit of educational material has been distributed to every public library in New Jersey. Contact with the local librarian will determine if this kit is being displayed and used by library patrons.

11. Information centers. Field Army volunteers may operate an information center. This should be at a spot easily found by the public. Volunteers staff the center, dispensing literature. On request, the list of doctors willing to conduct health maintenance examinations can be supplied. A list of nearby clinics can be given. Under no circumstances are information centers to recommend type of treatment, individual doctors or individual clinics where more than one exists in the county. If a patient has no family doctor and wants the name of a doctor who will give him an examination, he should be supplied with the list of all doctors in the area willing to conduct such examinations. The information center also can be used as a field army headquarters. Work room for dressings units and dental clearing point for motor corps scheduling.

There is a great need for funds for the research and medical service program. Information centers should be economically operated. It is advisable, wherever possible, to secure a location that is rent-free.

12. Study groups. Groups of men and women can be arranged for a series of meetings. This should be done with cooperation and approval of the county medical society and medical speakers should lead the discussion. It is possible to arrange such study groups as part of an adult evening school conducted in local public schools.

THINGS TO REMEMBER

1. The layman can't diagnose or cure cancer—that is the doctor's job.

2. Statements touching on medical phases of the program should always be approved by the county executive committee chairman.

3. The family doctor is the keystone of the detection program—go to him for an examination. But don't expect to drop in his office and have him spend nearly an hour unless you have made a prior appointment.

4. In the lay service program, see that dressings are properly made. "Sell" their use to doctors and hospitals. Let them know the dressings are available.

5. Do everything you can to dispel fear. Don't use "heart-pulling" speeches. Don't appeal to the emotions. That is a disservice to the public and to the cancer program. Point out cancer can be cured if detected early, be aware of the danger signals, see your family doctor.

NUTRITION IN EVERYDAY PRACTICE

S. William Kalb, M.D., Newark, N. J.
Chairman, Advisory Committee on Nutrition

1. *Is any special diet necessary for children who have rheumatic fever?*

   If there is a deficiency of protein, vitamin D, thiamine and minerals, this must be corrected by outlining a substantial nutritious diet and prescribing supplemental medication.

2. *Is cabbage a good source of vitamin C?*

   It is, but we don't get all the vitamin C it contains. The core of the cabbage contains the highest concentration of the vitamin and this is usually discarded. The loss of the ascorbic acid as a result of cooking by boiling or steaming is about 60 per cent. If it stands and is reheated, 90 per cent of the ascorbic acid may be lost.

3. *Do onions have any bacteriological properties?*

   This age old remedy does have a scientific basis for its therapeutic effects. Onion vapors are lethal to staphylococcus alba, typhus, and protozoa. If an onion is chewed for eight minutes, the buccal lining becomes sterile. This should exercise a desirable effect on sore throats resulting from colds. The action is obtained from the tear producing agent, (which is a thioaldehyde) and has proved bactericidal properties.

4. *Is there any relationship between myopia and nutritional deficiency?*

   In many patients, yes. Good results can be achieved with high doses of viosteral and calcium ascorbate.

5. *Do dehydrated foods have the same value as fresh foods?*

   Yes, they compare satisfactorily in regard to nutritional value.

6. *Will frozen baked pies, biscuits, and rolls retain their characteristics better than if frozen before they are baked?*

   In frozen pastry, hydrogenated vegetable shortening is superior in "keeping quality" to lard. Frozen unbaked pies retain the characteristics of fresh pies longer than those frozen after baking. Double acting baking powder is superior to the single acting when used in tea biscuits. Yeast rolls which are not kneaded keep in the freezer storage better than rolls which are kneaded.

7. *I have been using vitamin K routinely for two weeks before the expected date in my pregnant patients to avoid hemorrhage in the newborn. Recently I had a newborn with hemorrhagic disease. Should I have used it over a longer period of time?*

   It wouldn't have made any difference how long before delivery you gave vitamin K. It will prevent prolongation of the prothrombin time during the first week of life, but a prolonged prothrombin time is not an etiologic factor in the production of hemorrhage in the newborn. Hemorrhagic disease is rare. Most hemorrhages are the result of birth injuries or of anoxia induced by abnormal labor or delivery.

WHY DOCTORS SAY NO!

By Dr. Colville Barrington, MRCS, Huddersfield, England
Abstracted from the (Yorkshire, England) Daily Mail.

This is part of an item which appeared in a British newspaper in connection with the British National Health Service Act. It was submitted to the Journal by Dr. Lancelot Ely of Somerville, N. J., and is published here as a matter of interest and information.

"What advantages will the public obtain from the new Health Act? Free medical treatment, free hospitals, free nurses, free medicines. The public should realize that the scheme is not free. People will have to pay for this health program. The public is going to spend 152 million pounds* per year and the facilities offered cannot at present include one single extra doctor, nurse or hospital bed. Mr. Bevan has stated that construction of health centers (around which the scheme was to have been built) is out of the question at the moment.

"How much time will the doctor be able to spare

* At present rate of exchange this is about 600 million dollars. Since England has only a third of the population of the U. S. A., the corresponding American cost for such a program would be about $1,800,000,000.

for each patient? For the 4000 persons, allowable maximum, on his list, the doctor would have to render about 20,000 items of service. If he were allowed only two weeks' holiday a year, this would mean 70 items of service a day. Would the doctor take fewer patients and thus have more time for each? The answer is salary. The capitation fee is 15 shillings‡ per person per year. On this basis he would have to take more patients than he could properly attend. And let it not be forgotten that a third of his income would still have to be spent on office expenses.

"Are the doctors against a health service? No. In fact the idea originally came from them. But they are against this National Health Act. It gives the Minister unlimited powers; he could, by simple regulation, change the terms of service, thus making absolute his hold on the profession. As a salaried servant, the doctor would have to obey orders. A medical certificate, for instance, should be an honest opinion of the doctor as to the patient's fitness for work. No government department should be able to control a professional judgment.

"To the public, I say this: if the doctor's freedom of thought and action is lost now, yours will be sure to follow!"

‡ This is about $3 per person per year. At present, under the panel system, the average case load per physician in England is one thousand. On this basis, under the National Health Act, the average income would be $3000 a year per doctor. In the United States, the average case load per practitioner is 800. If the system were in effect here, at the same figures, average income would be $2400 total for the entire patients' panel.

SUPPLEMENTARY LIST No. 2 to the 1948 OFFICIAL LIST OF MEMBERS

Abers, Bernard D., 565 Summit av., Jersey City (9)
Amster, Milton W., 9 Chapman pl., Irvington (7)
Arbeit, Sidney R., 56 Gifford av., Jersey City (9)
Bitten, Robert, 11 Romaine av., Jersey City (7)
Borow, Benjamin, 507 Church st., Bound Brook (18)
Bruzza, George G., 415 Washington Blvd., S.Girt(13)
Cerchio, Michael P., 281 Newark av., Jersey City (9)
Clinton, James F., c/o DuPont Club, Parlin (12)
Colonna, Joseph A., 5016 Hudson av., W. N. York (9)
Denholm, John S., 1048 Coolidge rd., Elizabeth (20)
Dolganos, Moses, 268 Palisade av., Jersey City (9)
Downs, Roscius I., Evergreen Hall—Apt. 44, 430 Cooper st., Woodbury (3)
Ellenson, Solomon S., 507 Fourth av., Asbury P. (13)
Frost, Inglis F., 181 South st., Morristown (14)
Garbarini, John G., 93 Clifton pl., Jersey City (9)
Gibson, Charles F., 131 Federal st., Burlington (3)
Gilmour, John R., 144 S. Harrison st., E. Orange (7)
Goldberg, Jacob, 155 Franklin av., Long Branch(13)
Goodman, Stanley J., 89 Lincoln Park, Newark (7)
Guito, Frank J., 626 Mattison av., Asbury Park (13)
Harz, William V., 880 Avenue C, Bayonne (9)
Heisen, Aaron J., Emlaystown (13)
Hirsch, Albert, 1554 Irving st., Rahway (20)
Hogan, James J., 211 High st., Mount Holly (3)
Judy, Kenneth, 2741 Boulevard, Jersey City (9)
Kearney, John V., 335 78th st., North Bergen (9)
Lehman, Irving J., 31 Lincoln Park, Newark (7)
Loizeaux, Edward C., 320 East 7th st., Plainfield(20)
Lupo, Domenic, 763 Broadway, Newark (7)
Mangone, George F., 811 Palisade av., Union C. (9)
Martland, Harrison S., Newark C. Hosp., Newark(7)
Mast, Joseph E., 42 Westfield av., E., Roselle P. (20)
McCarthy, Cornelius P., 887 Boulevard, Bayonne (9)
Minella, Thomas J., 268 Springfield av., Summit(20)
Moore, John P., 16 Richmond st., Newark (7)
Moynahan, Brian S., 334 Washington av.,Bellev'le(7)
Newman, Abraham J., 132 Manhattan av., Jer. C. (9)
O'Gorman, Michael W., Med. Center, Jersey City (9)
Palmer, Harris H., 6 Willow Grove Pky.,Wesf'd(20)
Plain, Irving H., 88 Clinton av., Newark (7)
Potekhen, George P., 507 Park av., Plainfield (20)
Quaglieri, Charles L., 456 Fourth st., Hoboken (9)
Quinn, John J., 921 Bergen av., Jersey City (9)
Reilly, John J., Jr., 222 Elizabeth av., Elizabeth (20)
Reilly, Raymond P., 4912 Bergenl'e av.,W.N.York(9)
Rosenthal, Alfred E., 79 W. 32nd st., Bayonne (9)
Scala, H. Albert, 212 Garfield av., Jersey City (9)
Scalera, John F., 28 S. Plainfield av., S. Plainf'd (12)
Silberstein, Fred'k H., 4711 Westf'd av.,Merch'tv'e(4)
Stark, Harry L., 680 Hudson Blvd., Bayonne (9)
Stern, Morris H., 439 Clifton av., Clifton (16)
Stetser, Leland M., 922 Haddon av., Collingswood (4)
Thomas, Harry G., 1113 Fifth av., Asbury Park (13)
Tilley, John A., 165 Main st., Keyport (13)
Toren, Julius A., R.F.D. 1, Box 95, Long Branch (13)
VanHorn, Abram L., 744 Broad st.,R'm 901,N'w'k(18)
Weissberg, Jonas, 470 Jefferson av., Elizabeth (20)
Welkind, Allan A., 412 Bloomfield av., Caldwell (7)

ASSOCIATES

D'Alessandro, Genesio L., 279 N. 5th st., Newark (7)
Gardam, James D., 16 Longfellow av., Newark (7)
Kelly, John L., 82 Clinton av., Newark (7)
Rachal, Hurve J., 272 Orange st., Newark (7)
Silver, Albert M., 89 Lincoln Park, Newark (7)
Tarchiani, Lucius S., 494 River st., Paterson (16)
Underwood, Robert, 345 Washington av., Bellev'e(7)
Woodward, Arthur P., 47 Lincoln Park, Newark (7)

OPPORTUNITIES FOR PHYSICIANS

Excellent opportunities are available at the Veterans Administration Rating Boards for physicians interested in a 40-hour week job with a starting salary of $5905 a year, and an annual allowance of 26 days leave with full pay. Specialists are not required, as the training needed for rating board work will be furnished on the job. There is no Saturday, Sunday or evening work. Physicians interested in the possibilities here may obtain further details by writing to Chief of Personnel, Veterans Administration, 20 Washington Place, Newark 2, New Jersey, or by telephoning MArket 3-6800, extension 143.

OBITUARIES

DR. PETER BRANCATO

Dr. Peter Brancato, 65, ear, nose and throat specialist, died in Glendale, L. I., on March 22, 1948.

Born in New York City in 1882, Dr. Brancato was graduated from the College of Physicians and Surgeons of Columbia University in 1906. He moved to Paterson 30 years ago, and maintained offices until illness caused his retirement. Dr. Brancato was on the staff of St. Joseph's Hospital. He was a member of the American Board of Otolaryngology.

DR. CHARLES F. FISLER

Dr. Fisler, a practicing physician in Clayton for 53 years, died on April 26, at his home of a heart attack. He was the oldest member of the Gloucester County Medical Society.

Dr. Fisler was the son and the grandson of a physician. His grandfather helped to found Clayton, which at one time was known as Fislerville. Dr. Fisler was born in 1873 and was graduated from Jefferson Medical College in 1895. He had served as registrar of vital statistics of Clayton and had been a member of the board of health.

DR. GERALD HIGGINS

Dr. Gerald L. Higgins of Jersey City, died suddenly on April 10 at his shore home in Avon, at the age of 57.

Dr. Higgins was a graduate of the University of Maryland Medical School, receiving his degree in 1915. He practiced in Jersey City and was a member of St. Elizabeth's Holy Name Society, Avon, the Aesculapian Medical Society and the Major John W. Desmond Post, American Legion.

DR. AUGUSTUS S. KNIGHT

Dr. Augustus S. Knight of Far Hills, died on March 21, 1948, at Somerset Hospital of injuries received in an automobile accident on March 15.

Dr. Knight was born in Manchester, Mass., in 1864. He received his medical degree at Harvard Medical School in 1891. After serving his internship in Boston City Hospital, Dr. Knight became an instructor of physical diagnosis in Harvard Medical School. At the same time he was a member of the Boston Dispensary staff and served as registrar of Boston City Hospital until 1892, when he was made a medical examiner for Metropolitan Life Insurance Company. In 1899 he became medical director of Metropolitan, holding that position until his retirement in 1933. He was credited with starting life insurance companies offering periodic health examinations to policy holders.

In 1917 he was elected to the Somerset Hospital Board of Trustees, served as president of the Hospital from 1937 to 1946 and was chairman of the Board of Trustees since 1946. He was appointed to the Board of Managers of Greystone Park State Hospital and was president of the Board since 1937. His affiliations included fellowship in the American College of Surgeons and membership in the Association for Research in Nervous and Mental Diseases and the National Committee for Mental Hygiene. He was a member of the Somerset County Medical Society and an honorary member of the Morris County Medical Society and of the Medical Society of Greater New York.

DR. JOHN L. LUND

Dr. John L. Lund, a practicing physician in Perth Amboy for 55 years, died on February 21, 1948, after a short illness.

Dr. Lund was born in Denmark in 1868. He was graduated from Long Island College of Medicine in 1891 and had served as city physician and a member of the Board of Health of Perth Amboy. Dr. Lund was retired dean of Perth Amboy General Hospital and was an honorary member of the Middlesex County Medical Society.

DR. LESLIE C. LYON

Dr. Leslie C. Lyon of Magnolia died in the Camden County General Hospital at Lakeland on March 30, 1948.

Dr. Lyon, whose family for ten generations had included physicians, was born in 1873. He received his medical degree in 1898 from the Medical-Chirurgical College of Philadelphia. Dr. Lyon was an honorary member of the Camden County Medical Society.

DR. JOHN W. MARCY

Dr. John W. Marcy, retired Merchantville physician, died on March 8, 1948, at the age of 85. He had practiced in Merchantville 60 years.

Graduated from the University of Pensylvania School of Medicine in 1885, he practiced for a year in Clearfield, Pa., before moving to New Jersey. He was the second physician to practice in Merchantville.

He was an honorary member of the Camden County Medical Society, of which his father was a founder.

DR. WILLIAM MARTIN

Dr. William Martin, who retired a year ago after practicing during a long career in Bristol, Pa., Atlantic City and Collingswood, died on March 19, 1948, at his home in Haddonfield.

Born in 1868, Dr. Martin received his medical degree at Jefferson Medical College in 1889. He was a past president of the Electro-Therapeutic Society and was an honorary member of the Atlantic, Camden and Philadelphia County Medical Societies.

DR. WALTER B. MOUNT

Long a key figure in New Jersey Obstetrics, Dr. Walter B. Mount died on March 12, 1948. Born in New York in 1880, Dr. Mount attended the Lawrenceville School and was graduated from Princeton in 1901. He entered the College of Physicians and Surgeons that year and won his M.D. in 1905. Almost immediately he entered the field of gynecology and obstetrics, accepting a residency at the Sloan Hospital in New York. During World War I he served in the Medical Corps of the Army. Always active in organizational affairs, he served at

one time or another as an officer of the Associated Physicians of Montclair, the Essex County Medical Society, the American Legion, the Maternal Welfare Commission, the Society of Surgeons, and the Orange Clinical Society.

He was a diplomate of the American Board of Obstetrics and Gynecology and was senior obstetrician to all three hospitals in Montclair.

DR. WILLIAM A. NORVAL

Dr. William A. Norval, one of the first seven members of the Passaic County Board of Freeholders and former county physician, died at his home in Clifton at the age of 72, on March 26, 1948.

A native of Paterson, Dr. Norval, following his graduation from Baltimore Medical College in 1897, was connected with St. Joseph's Hospital, Barnert Memorial Hospital and Paterson General Hospital until World War I. He saw active service in the Argonne Forest where he was wounded. He was an honorary member of the Passaic County Medical Society.

DR. CHARLES H. SCHLICHTER

"Noted physician, zealous executive, esteemed citizen". These words engraved on the plaque of the Edward J. Ill Award, signal the qualities which marked half a century of Dr. Schlichter's extraordinary service to the community and to the profession. In the presentation of that coveted Award, Dr. Earl LeRoy Wood summed up compactly the unique and endearing position which Dr. Schlichter held in the hearts and minds of his brother physicians. "On many occasions" said Dr. Wood to Dr. Schlichter "public duty demanded so much that your personal interests, private practice and individual convenience were sacrificed. This you bore without complaint. Courageously you have championed policies, when convinced of their justice or necessity, undeterred by the prospect of disapproval and certainty of opposition".

Dr. Schlichter's death came with stunning suddenness. He had just left our Annual Meeting and returned to his home in Elizabeth. Within five minutes after his arrival at home, he was gone. Thus was snuffed out one of the truly great careers in New Jersey medicine. Dr. Schlichter served the nation in three wars beginning with a junior medical corps lieutenancy in the Spanish-American War and ending with the difficult and exacting job of chairman of procurement and assignment for physicians in World War II. A mere recital of his services to the nation, to his home community, to his profession, gives some idea of the man's stature and breadth. State Commission for the Blind, president of the Elizabeth General Hospital staff, president of the Elizabeth Public Library, chairman of our state society's Welfare Committee, chief of eye-ear-nose-and-throat at many hospitals, president of the Board of Water Commissioners, president of the Union County Medical Society, senior consultant to the U. S. Public Health Service—the list could be extended indefinitely. Dr. Schlichter had commanded army hospitals, written ERA medical contracts, served as an ophthalmic consultant to numerous hospitals, earned the commendation of two Surgeons General.

He was thus one of the grand old men of a grand old age; an age when doctors could be healers, public spirited citizens, top-notch administrators, and—in every sense of the word—gentlemen.

DR. HOMER I. SILVERS

Dr. Silvers, one of Ventnor's leading surgeons, died at his home on April 7, from a heart ailment.

Dr. Silvers was born in 1880. He was graduated from the Hahnemann Medical College in 1903 and also studied in Vienna. He began his practice in Ventnor in 1906, after serving two years as assistant surgeon in the National Homeopathic Hospital in Washington.

Dr. Silvers was widely known in surgical circles, particularly in the field of proctology in which he was a recognized specialist. At the time of his death he was surgical director of Atlantic City Hospital. The recipient of many medical honors during his long career, Dr. Silvers was elected president of the American Proctologic Society in 1942, after serving as councilor for the previous two years. He served as president of the Ventnor City Board of Health since 1936 and had been a member of the Atlantic County Mosquito Extermination Commission for the past four years. During both world wars, Dr. Silvers served in an emergency capacity.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

Ask each patient you admit to a hospital: "Are you enrolled in Medical-Surgical Plan of New Jersey?"

When a patient, not entitled to full service benefits in accordance with the Schedule of Benefits of the Plan, requests the services of a Participating Physician, the patient and physician should agree in advance on the amount of the total fee.

The Board of Trustees of the Plan believes that the patient is entitled to know the cost of a physician's service at the time the service is requested.

Norman M. Scott, M.D.

THE BULLETIN BOARD

HELPING OUR NEW MEMBERS

The Medical Society of New Jersey, through its delegates to the American Medical Association, has interested itself at various times in proposals to give medical students throughout the country some training, at least elementary, in the socio-economic problems of medicine, the functions and policies of medical societies, and the responsibility of the young physician in helping to determine the destiny of his profession. This is certainly a commendable, much needed project. Medical students train and study in a more or less cloistered atmosphere. The intensity of their scientific training these days is such that few of them have an opportunity to become well informed on the social problems facing medicine.

The need for such training in medical schools is obvious, and nothing should persuade us to drop the effort to accomplish this objective. Meanwhile, there is something we might do ourselves to help the young graduate physician —the neophyte member of organized medicine—to become better acquainted with the purposes of medical societies, their place in the community, and the means by which a young physician can make his influence felt in the affairs of organized medicine.

Some medical societies, here and there, have done impressive work along these lines. Frequently they call it "indoctrination" of new members. Sometimes the word "orientation" is used. The term "indoctrination" seems to us to have a slightly totalitarian ring. In any event, it sounds like a formal and formidable process, which is not what we have in mind. The word "orientation" also, we think, is not a happy choice. It may have meant something once, but it has been kicked around by bureaucrats and other devotees of gobbledegook and has lost most of its usefulness.

We would prefer to call it "helping the young physician". Recently Dr. George S. Klump of Williamsport, Pennsylvania described an informal project carried on in his county medical society, for the benefit of new society members. According to Dr. Klump, the plan produced good results, not the least of which was the understanding and tolerance it induced in the old members charged with the responsibility of reviewing organized medicine's aims and ideals. In general, Dr. Klump feels that the training program should be carried on in an informal atmosphere, preferably at an unhurried dinner meeting, and with all the perquisites of friendly good fellowship.

Dr. Klump found that all new members are interested in discussing such things as medical ethics, the objectives of organized medicine, public and professional relations of physicians, the physicians' relationship to the hospital, etc.

As to medical ethics, Dr. Klump recommends that each new member be provided with a copy of the "Principles of Medical Ethics" of the A. M. A. In discussing ethics, he feels that the idealism of the profession should be emphasized.

Similarly, in acquainting the young doctors with the objectives of organized medicine, "constant emphasis should be given to the principle that medical organization is first concerned in serving the interests of the people."

Under the heading of public and professional relations, there were discussions of fees, consultations, participation in constructive programs of organized medicine, community leadership on the part of individual doctors, and the all important topic of the relations between the physician and his patient.

In regard to fees, Dr. Klump feels that a discussion of the local fee schedules or accepted levels of fees and a thorough explanation of the usual charges in the community is extremely helpful to the young doctor. "The unfortunate public relations resulting from over treatment, overcharging, fee splitting and acceptance of rebates or kickbacks," Dr. Klump felt should be emphasized.

The desirability of young physicians being well acquainted with the need for consultation and the proper methods of conducting consultations hardly needs to be mentioned.

All physicians should take some part in the activities and especially the policy determinations of organized medicine. Also, every young doctor should take part in the programs of health and welfare groups, service groups, churches, and other organizations in his community.

But Dr. Klump points out that a formal "indoctrination" (the word is his) of new members is not enough. "It may be made even more effective," he suggests, "by following through with invitations to departmental and general staff meetings at a hospital, aiding the new member in his application to the credentials committee for courtesy privileges or a

staff appointment, in accordance with his ability and training, and urging him to confer frequently with one or two of his older colleagues about any matter that requires clarification. Last but not least," Dr. Klump concludes, "don't forget to include his wife in the program of indoctrination through the Woman's Auxiliary".

WHAT IS AHEAD IN MEDICAL PUBLIC RELATIONS?

In a keynote paper presented at a Public Relations Roundtable of the Council on Medical Service of A.M.A. in Cleveland last January, Mr. George H. Saville, Public Relations Director of the Ohio State Medical Association, offered the following stimulating prognosis of public relations trends in medical societies:

"In my opinion, the most significant scene on the horizon of modern medical public relations is that it is beginning to dawn on the medical profession that good public relations cannot be acquired overnight by publicity alone, important as good publicity is. It is being recognized that the best source of good public relations and good publicity is conscientious service by the practicing physician to his patients and constructive service by organized medicine to the public-at-large.

"Second: I see the concept of medical public relations changing from the huckster type of press-agentry to the realization that every activity of medical organization, either directly or indirectly, affects the relations of the public with the medical profession. The effect is good or bad, depending on whether these activities are positive and constructive or negative and destructive. That brings me to the third point.

"Third: The horizon of medical public relations is glowing with positive action. Not many years ago it was a dull picture of a doctor denouncing, opposing, or viewing with alarm any changes in the status quo. We now have the bright picture of the medical profession itself agreeing that there is need for the better distribution of medical care, and doing something about it—not merely saying 'We are agin' the solution proposed by the Wagners- Murrays and Dingells'. The fostering of medical care plans; the encouragement of young doctors to enter rural practice; cooperation with other health groups in the establishment of full-time public health units, and better school health programs are just a few of the activities of many medical societies that indicate a growing trend towards the constructive approach, the approach which generates good publicity."

It is interesting to observe that The Medical Society of New Jersey is taking an active part in three of the four programs mentioned by Mr. Saville in the last quoted paragraph above. We haven't yet done much about encouraging young doctors to enter rural practice. But we are certainly out in front in fostering medical care plans, in promoting establishment of full-time public health units, and in attempting to improve the school health work in New Jersey.

BENEFIT OF A MEDICAL SCHOOL

Current revival of interest in the possibility of establishing a medical school in our State lends special interest to an editorial on "The Contribution of a Medical School to the Health Program of a Community", appearing in the *Journal A.M.A.* for February 21, 1948.

"A medical school can make important contributions to the health program of the community in which it is located," this editorial asserted.

Pointing out that "medical schools are no longer merely centers for undergraduate instruction more or less isolated from their communities," it noted that "American medical schools are making increasing contact with all phases of medical care. The community looks to its medical schools for leadership in formulating and directing better forms of medical service. Medical schools are accepting this challenge and within the capacity of their resources are seeking to place their personnel and facilities at the service of the people of the area in which they are located."

"Today," the editorial continued, "the medical school is an acceptable agency for integration of medical and health resources in a community-wide cooperative program for the better health of more persons . . ."

While it was granted that maintenance of a medical school is a major operation from the financial point of view, nevertheless, the A.M.A. editor remarks that "in terms of the benefits that will accrue to the community, the amounts (of the original investment and maintenance) are small". It is suggested that a medical school's community health program should be coordinated with the activities of other health resources in the region; that the school should be the hub of a network of facilities for medical education, research, medical care, and community health programs. "The program contemplated," it is concluded, "especially when integrated with voluntary prepaid insurance plans, will go much further in providing adequate medical care of high quality than any alternative scheme thus far proposed and at much less cost."

James E. Bryan,
Executive Officer.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

"Introducing You to Carville" is the title of a newly released booklet issued by the U. S. Marine Hospital, Carville, Louisiana. Prepared for distribution to patients, it gives a history of the hospital, information regarding leprosy, a summary of hospital departments and activities and routine instructions. Copies are available from F. A. Johansen, Medical Director, U. S. Marine Hospital, Carville, Louisiana.

HEALTH FILM CATALOGUE AVAILABLE

Health films are now provided by the New Jersey Department of Health and available on loan from the State Museum, State House Annex, Trenton 7, New Jersey. A good working catalogue of these films is the 1948 *Health Films Catalogue* issued by the Division of Health Education, State Department of Health, Trenton 7, New Jersey.

Films are listed under cancer, dental health, general health, industrial health, nutrition, sanitation, tuberculosis, and venereal diseases. Most of the films are sound, all are 16mm, and a projector and operator must be supplied for local use. There is no charge for the catalogue or for use of the films.

HOW TO TAKE A BLOOD SPECIMEN USING THE OLD TYPE WASSERMANN NEEDLE

The Bureau of Bacteriology has been receiving questions concerning the technic for the use of the blood-letting needles now being supplied in syphilis serology outfits (Bact 694).

The Petroff needle previously supplied has so increased in price that the Bureau has found it necessary to discontinue its purchase.

The following instructions are submitted for those having difficulty using the needles now being supplied:

A. Hold the tube or vial between the last fingers and the palm of the hand; grasp the needle at the hub between the thumb and the first finger, so that the hub rests on the lips of the tube. Have a tourniquet applied to the patient's upper arm to engorge the veins. If the skin is held down firmly with the left hand it is easier to enter the vein.

B. Some physicians prefer to hold the needle with a hemostat, pressing the tube against the handles, with the hub of needle at the lip of the tube. The rigidity gained by this method makes it easier to enter the vein.

C. Others prefer to hold only the needle in the right hand. It is held at the hub between the forefinger and the thumb. A piece of absorbent cotton is placed at the end of the needle opposite the point and as soon as blood appears on the cotton, the tube or vial is quickly substituted and the specimen collected.

HOSPITAL PENICILLIN TREATMENT IN SYPHILIS

Until further notice, all classifications of syphilis will be accepted for hospital treatment with penicillin.

The period of hospitalization has been extended from five to eight days, with additional time authorized for early congenital syphilis (less than four years) and syphilis of the central nervous system.

Dosage also has been increased — 50,000 units every two hours to a total of 4.8 million units of aqueous penicillin, with additional amounts for central nervous system syphilis.

Minimum requirements are a positive darkfield or a positive report on the blood or spinal fluid.

The procedure for admitting patients has not been changed. The physician makes arrangements for a bed with his local hospital, fills out the upper half of the application form and sends the application form to the hospital with the patient.

Medical Center, Jersey City, will accept patients from any part of the state—the patient should report to the Admissions Office between 9 a. m. and 4 p. m. with an application signed by his physician.

Symptomatic neurosyphilis. Fever therapy with penicillin is recommended for cases of paresis, tabes dorsalis, primary optic atrophy. In a recent letter physicians were instructed to refer patients to Medical Center, Jersey City for fever therapy—unfortunately this offer must be recalled, at least temporarily. Some of the symptomatic cases are improved by penicillin alone—hospitalization up to 20 days and a maximum of 20 million units of penicillin is authorized when a hospital bed is available. As in the past, patients eligible for state mental institutions should be committed to such institutions.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held at the Traymore Hotel on Friday, April 9, 1948, at 9 p. m., with Dr. Clarence Whims, the president, presiding. Dr. Corscaden, clinical professor of gynecology at Columbia University, spoke on *The Early Diagnosis and Treatment of Uterine Cancer.*

He introduced his subject by listing under captions causes for poor results in the treatment of cancer such as: 1. Failure because of the patient. 2. Failure because of the doctor. 3. Failure because of the therapist.

In order to obtain the best results, one must accurately differentiate between functional uterine bleeding and organic. He touched upon the fact that there are many doctors treating a case for functional bleeding whereas an organic condition exists.

He stated that the best treatment for cervical cancer is radium; for cancer of the uterine corpus, radium followed by hysterectomy is commonly employed.

Dr. Corscaden illustrated his entire paper with excellent lantern slides. The discussion was led by Dr. Edward Uzzell followed by many of the members present.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

Regular meeting of the *Bergen County Medical Society,* held at Bergen Pines Hospital, Oradell, on the evening of April 13, 1948, was called to order by the president, Dr. Rudolph C. Schretzmann, at 9:08 p. m.

On recommendation of the membership committee, the following were elected to full membership: Drs. James R. Scheip, Oradell; Laborio B. Spitaleri, Lodi.

The secretary reported that Dr. H. B. Wilson, chairman of the nominating committee, submitted the following candidates for office in 1948-1949: President, Dr. Luke A. Mulligan; Vice-President, Dr. John L. Olpp; Secretary, Dr. Edward V. Sexton; Treasurer, Dr. Frederick L. Muller; Reporter, Dr. Nelson C. Walker. This list of candidates will be presented at the annual meeting on May 11, at which nominations may be made from the floor.

The president reported that the Woman's Auxiliary to the Bergen County Medical Society was holding its meeting this evening in another part of the hospital and said that at the conclusion of the meeting the Society will be the hosts of the Auxiliary.

The following doctors were introduced by Dr. George M. Knowles, chairman of the scientific committee, and their discussion of the evening was on *Laboratory Procedures in Hospital and Office Practice:* Dr. Christian P. Segard, chairman, Wisconsin Alumni Research Foundation; Dr. Maurice Bruger, associate clinical professor of medicine, New York Post Graduate Medical School; Miss C. A. Welsh, chief medical technician, Bergen Pines; Dr. Howard M. Mayer, Hackensack Hospital; Dr. I. Gaspar, Englewood Hospital; Dr. Luther A. Markley, Holy Name Hospital; Dr. Samuel B. Reich, Hackensack Hospital.

Dr. Maurice Bruger gave a most interesting lecture on *Recent Advances in the Estimation of Liver Function.* Demonstration of liver function tests and simple laboratory procedures by the department of laboratories, Bergen Pines Hospital, concluded the program of the evening. The demonstration included an outline of the liver function tests and a demonstration of some of them—blood smears showing various types of blood dyscrasias, prepared specimens showing ova and parasites and a simple test for albumin, sugar, acetone and bile in the urine.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

As is the custom in the Burlington County Medical Society one monthly meeting a year is devoted to case reports of patients of the members of the Society. This year on April 8, 1948, the *Burlington County Medical Society* held its annual case reports meeting at the Riverton Country Club.

Dr. Thomas J. Summey was first on the agenda and his topic was "Radical Resection of the Head of the Pancreas for Malignancy". He related the history of radical resection of the pancreas due to carcinoma of the ampula of Vater. By the use of slides Dr. Summey showed how the operative technic had changed from the first operation to the methods used today. He told about a recent operation of his of this type and the progress of the patient post-operatively. Although this type of operation is not necessarily curative it usually adds one to three years to the patient's life.

Dr. Arthur B. Peacock presented a case of icterus in a white female seventy-two years old. He stated that the patient had intermittent attacks of jaundice for about a year. During this time there would be acute exacerbations of pain, fever and jaundice and symptoms of pneumonia. Later she developed a mass in the epigastrium. He described all her signs and symptoms in detail and paused to permit the members to make their diagnosis. After this discussion Dr. Peacock continued and told of the findings uncovered at necropsy which were a mass of adhesions in the epigastric area and two stones in the ampula of Vater which had a ball-valve action. No malignancy was present.

Dr. Luis Viteri described his case of a forty-two year old white male who had had nausea, vomiting, icterus and a low grade fever for four to five months and also a moderately enlarged and tender liver for the last month or two of his life. After fully describing the symptoms and signs of his patient the speaker paused for discussion among members after which he described the findings at necropsy which were carcinoma of the second part

of the duodenum with metastases, nephrosis and gastritis. Cancer of the second part of the duodenum is very rare and occurs in about three per cent of gastro-intestinal carcinoma.

DR. E. VERNON DAVIS spoke on non-union of the clavicle of a four year old child. He reviewed the cases which were reported in medical literature. Then he described the operation which he performed to cure this condition. He went on to say that non-unlon of the clavicle in a child is a rare condition but should always be kept in mind when treating such a case. Surgical intervention is usually curative.

DRS. HARRY B. MARK and S. EMLEN STOKES presented the case of a nine-month old female baby which apparently contracted a rather innocent looking upper respiratory infection. Forty-eight hours later the baby developed a high fever and convulsions which lasted for three days. After a very detailed description of all signs and symptoms the hospital course was discussed. The apparently innocent respiratory infection resulted in an encephalitis and has left the child in a mentally retarded state.

These case report meetings have always proved to be one of the most interesting meetings each year and this meeting was certainly no exception. It was very instructive and the members entered into each discussion with eagerness.

The secretary read a letter from the State Society requesting that the doctors in each community arrange between themselves a schedule so that there will always be a doctor on duty for night calls and over weekends.

Dr. S. Emlen Stokes had a request from the State Board of Child Welfare asking that the same procedure be applied to this Board as the one which is working so well with the County Committee on Old Age Assistance. The Society approved this request.

DR. JAMES J. HOGAN of Mount Holly was elected to membership.

The Blood Donor Plan of the Red Cross which was discussed at the last meeting was brought up again. It appears that there has been a change in policy which is not looked upon with favor by the County Society. As a result the County Society unanimously rejected the plan as it now stands.

CUMBERLAND COUNTY

E. C. Greene, M.D., Reporter

An unusually lengthy business meeting preceded the guest speaker at the April meeting of the *Cumberland County Medical Society,* held April 13, 1948, at the White Sparrow Inn on Delsea Drive in Vineland. DR. SIDNEY L. SIEGEL, retiring president, presided.

Dr. Anthony Pino reported for the County Cancer Committee, stating that funds are now available for the operation of the three clinics in the county as follows: $1500 for radium, $900 for instruments and equipment, and the remainder for a nurse-secretary to assist in the administration of the clinic. Dr. Pino stressed these points of policy by which the clinic will operate: no patient will be admitted except by request from his attending physician; a written report will be sent to that physician and no treatment will be undertaken until he has been informed. Dr. Pino's excellent service in the administration and organization of the committee was commended by the society.

Dr. Pino also reported on the meeting of the Post Graduate Educatlon Committee which he had attended in Trenton, March 21. He announced that short lecture courses will be available to members of the society through the facilities of the Rutgers University Extension. After a discussion as to what type of lectures would be desired, it was decided that a committee be appointed to study the quesion.

The nominating committee recommended the following panel of officers for 1948-49, all of whom were unanimously elected: *President,* Dr. Charles Cunningham; *President-Elect,* Dr. Anthony Pino; *Secretary,* Dr. Mary Bacon; *Treasurer,* Dr. Herbert H. Wilson; *Censors,* Dr. Carl Ware and Dr. Charles Gray; *Executive Committee,* Dr. A. B. Kump, Dr. G. M. Thomas, and Dr. L. J. Kauffman; *Delegates,* Dr. A. B. Kump, Dr. H. Burton Walker, and Dr. Sidney Siegel; *Alternate Delegates,* Dr. Carl Ware, Dr. Arthur Sewall, and Dr. Kenneth Corson; *Reporter,* Dr. Arthur Sewall; *Nominating Committee,* Dr. A. B. Kump with Dr. H. Burton Walker as alternate.

The following resolution was adopted:

> WHEREAS: God in His wisdom has seen fit to remove from our midst DARE WOODRUFF, our fellow practitioner and member of our society; and
>
> WHEREAS: Dare Woodruff has been a proficient doctor of medicine, a patient and tolerant counselor and a good and honest man, be it therefore
>
> RESOLVED: That this resolution of regret in his passing be spread on the minutes of our society and a copy be sent to his family to aid them through their hour of bereavement.

Dr. Charles Cunningham, chairman of the program committee, introduced the guest speaker, COL. PAUL I. ROBINSON, Chief of Personnel Division, Surgeon General's Office, U. S. Army, whose topic was *Procurement of Medical Officer Personnel and Their Career Management.* With the present threat of war, his presentation of the Army's plans for the procurement of medical officer personnel and their organization was of particular interest to members of the age group for selective service.

ESSEX COUNTY

Asher Yaguda, M.D., Reporter

The April meeting of the *Essex County Medical Society* was held on Thursday, April 8, 1947, at the Academy of Medicine of Northern New Jersey, Newark.

DR. HARROLD MURRAY, president of the Essex County Medical Society, called attention to the designation of April as Cancer Control month and urged the doctors to support the fund drive of the American Cancer Society, which had already spent more than $100,000.00 for the establishment and equipment of cancer clinics at eight hospitals in Essex County.

DR. JOSEPH I. ECHIKSON, chairman of the Cancer

Committee, introduced the speaker of the evening, Dr. Lloyd F. Craver, of the Memorial Hospital of New York who spoke on the "Recent Advances in the Treatment of Lymphomas, Leukemia and Allied Disorders". Dr. Craver stated that the recent efforts to control these conditions could be divided into two categories: (1) chemotherapeutic and (2) radiotherapeutic.

While none of the chemotherapeutic agents used thus far have shown any curative properties, experience has demonstrated that some of these agents have definite palliative worth. Of these, the nitrogen mustard drugs are the most promising. Based on the results in over 300 cases treated at the Memorial Hospital, Dr. Craver felt that he could make the following statements relating to the nitrogen mustard drugs: (1) The nitrogen mustard compounds used so far have not cured, nor have they shown any evidence indicating a possibility that they can cure, any form of lymphoma or leukemia. (2) The nitrogen mustards, especially the methylbis compound (HN2) may have a marked palliative effect, particularly in Hodgkin's disease with toxic symptoms by producing a rapid detoxification in a few days as compared with the much longer period of time needed with x-ray therapy. (3) Remissions when produced are disappointingly short, as a rule. (4) Nitrogen mustard is not applicable to early localized stages of these diseases. These do better on local x-ray therapy.

Of the other drugs recently used in the treatment of the lymphomas and leukemias, stilbamidine and urethane have received the most attention. Stilbamidine has been reported to be useful in relieving pain in multiple myeloma. It is not a cure but is a palliative and is thought to inhibit the advance of plasma cell myeloma in the bone. Urethane, because of its ability to produce a leucopenia, has been tried in the treatment of the leukemias. Its effect is unpredictable and is obtained in only about one-third of the cases of chronic leukemia in which it is used. It is purely palliative and has no appreciable effect on the course of the leukemia.

Advances in radiation therapy of the lymphomas and leukemias have been through the development of better technics of application of external radiation and through the introduction of internal radiation by means of radioactive isotopes, chiefly those of sodium, phosphorus and manganese. The radioactive isotopes, when introduced into the body, are taken up by the immature cells and act by exerting a continuing irradiation. Dr. Craver again emphasized that these drugs do not cure but offer a means of palliation and a new avenue of approach for further study and experiment. The radioactive isotope of phosphorus has been found to be useful in the treatment of polycythemia vera and in the chronic leukemias.

GLOUCESTER COUNTY

L. K. Collins, M.D., Reporter

The *Gloucester County Medical Society* met at the Woodbury Country Club, April 15, 1948, with the president, Dr. Joseph F. Hughes, in the chair. Several members of the Salem County Medical Society were welcome guests.

Dr. Wendell Burkett reported for the Legislative Committee. Dr. Louis Collins, reporting as a delegate to Cumberland County, discussed the talk made there by Col. Robinson, Chief of Personnel, Surgeon General's Office. Col. Robinson described the proposed selective service act and the expected need for physicians under this bill.

Two speakers from Trenton were on hand for the scientific program, the first being Luman Tenney, M.D., director of the N. J. State Mental Hygiene Clinic. Dr. Tenney, with the aid of a map, located the various mental hygiene clinics emanating from Trenton. The purpose of the clinics and the mechanism of referring patients was described. Dr. Tenney hoped that additional clinics could be set up to take care of the neglected southwestern part of the state, but at present the small staff and travel factor from Trenton make this impossible. The field of mental hygiene and the relation of the clinics to the family physician were ably discussed by Dr. Tenney.

The second speaker was Robert S. Garber, M.D., clinical director of Trenton State Hospital. Dr. Garber traced the history of the institution from Dorothea Dix to the present time, one hundred years of progress. The routine progress of the patient from admission through evaluation following complete physical and mental examination to treatment and possible discharge was described by Dr. Garber. The speaker then went over the two methods of admission, voluntary and involuntary, and stressed the fact that the law insisted that these forms be completed before admission even in the case of an actual emergency. The speakers then answered many questions.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting on March 2, 1948, at the Jersey City Masonic Club. Dr. Driscoll presided.

Mr. Harry F. Downes, president of the Jersey City Health Council, presented a brief resume of the activities of the Council since its inception about twenty-five years ago. He expressed the opinion that a sponsorship of the Council by the Hudson County Medical Society would prove mutually advantageous. A motion was made, seconded and carried that the Society sponsor the Jersey City Health Council in accordance with the recommendation of the executive committee on February 16, 1948, and in line with the general plan outlined by the Council on Medical Service, the American Medical Association.

The report on nominations for the year 1948-49 was presented by Dr. J. L. Evans, chairman of the nominating committee.

The guest speaker of the evening was Elmer L. Sevringhaus, M.D., director of clinical research, Hoffmann-LaRoche, Inc., Nutley, N. J.; formerly professor of medicine, University of Wisconsin; consultant on endocrine and nutritional disorders. Dr. Sevringhaus selected as his subject: *Vitamin Therapy in General Practice*. Drs. White, Landshoff and Jaffin were discussants. The speaker received a rising vote of appreciation.

HUNTERDON COUNTY

H. A. Davidson, M.D., Reporter

Historic Clinton House was the scene of the Annual Meeting of the *Hunterdon County Medical Society,* held under the chairmanship of the retiring president, DR. RAYMOND J. GERMAIN on May 4, 1948. Notice was taken of the reception given by the community of Bloomsbury to DR. EDGAR LANE, and of the colorful feature article on the affair in the New York *Herald-Tribune.* The society ordered this gratifying tribute to one of its members, spread on the minutes as a permanent part of its archives.

The society voted to create a subcommittee on school health as a subdivision of the public health committee. Mr. James E. Bryan, Executive Officer of The Medical Society of New Jersey attended the meeting, and on invitation spoke of his work on behalf of organized medicine. DR. BYRON HARMON, who, a quarter-of-a-century ago was president of the Hunterdon County Medical Society and who is now a public health official in Florida, was also present and spoke briefly of public health practices in the Peninsula State.

Elections were held and the following were selected for office: President, Dr. Edwin D. Merrill; President-Elect, Dr. John Fuhrmann; Vice-President, Dr. Lloyd Hamilton; Secretary, Dr. Philip W. Baker; Treasurer, Dr. Barclay Fuhrmann; Reporter, Dr. Henry A. Davidson; Adviser to the Womans Auxiliary, Dr. Lloyd Hamilton; Executive Officer, Dr. Barclay Fuhrmann.

MIDDLESEX COUNTY

A. J. Pellicane, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on March 17, 1948, at Roosevelt Hospital, Metuchen, with the president, DR. EDWARD F. KLEIN, presiding. The meeting was called to order at 9:10 p. m.

The minutes of the February meeting were read and approved.

Dr. Charles F. Church, chairman of the nutrition committee, discussed the Oleomargarine Bill which is to be considered in the near future by the State Legislature. He presented, as his committee report, a resolution which favored the passage of a bill permitting the manufacture and sale of colored oleomargarine in New Jersey. On regular motion, this resolution was approved.

The medical ethics committee report was given by Dr. Charles H. Calvin, chairman. DRS. RAYMOND J. GADEK, Veterans Administration Hospital, Lyons, and FRANK PARET, New Brunswick, were elected to a two-year period of Associate membership.

The public health committee report with their four-point recommendation, was presented by Dr. H. P. Fine, chairman.

Dr. John H. Rowland, chairman of the chronic diseases hospital committee presented his report which included a survey of the facilities available in Middlesex County for the hospital care of the chronic ill, and the total number of patients requiring such care. It was the recommendation of this committee that an additional 300 beds be made available for the care of those suffering from chronic diseases; this addition to be built to the present Middlesex County Hospital for the Chronically Ill, Georges Road, North Brunswick Township. On proper motion, the society approved this recommendation and requested that it be brought to the attention of the Board of Freeholders of Middlesex County.

The report of the post-graduate education committee, presented by the chairman, Dr. F. M. Clarke, was read and placed on file. Dr. Clarke requested that the members of this society give the question of the subject matter to be offered some thought so that courses of greatest interest to the membership could be arranged.

Dr. Cyril I. Hutner, chairman of the speakers bureau reported on the committee's activities to date. He pointed out the difficulties in arranging proper speakers for the various meetings and asked for greater cooperation from the general membership. On motion, the activities of the speakers bureau were approved, with the suggestion that further publicity, both within the society and in the public press, be developed.

Consideration of the formation of a new Code of Ethics for the Society was then taken up under the supervision of F. M. Hoffman, M.D., chairman of the revision of the code of ethics committee. Sections of the proposed Code were read and approved where no objection was voiced. The controversial sections were thoroughly discussed and such changes as directed by the members present were made. Because of the lateness of the hour, the remainder of the proposed ethics program was postponed for consideration at a later meeting.

On proper motion, a vote of thanks was offered Dr. Harry J. White, for his generosity in furnishing the increase in the menu offered at the close of each meeting, at no expense to the Society.

Dr. Klein announced the membership composing the new inter-hospital staff committee. Dr. W. E. Sherman has been appointed as temporary chairman to facilitate the organization of this committee.

A motion was passed that insurance examination fees be increased from five dollars to ten dollars, in Middlesex County, in conformity with resolution already approved by The Medical Society of New Jersey.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The regular monthly meeting of the *Monmouth County Medical Society* was held at the auditorium of the Monmouth Memorial Hospital at Long Branch, March 24. The guest speaker, DR. O. G. LOWSLEY, director of the James Buchanan Brady Urological Foundation, was introduced by Dr. Byron Blaisdell. "Newer Procedures in Urological Surgery" was the paper presented. Dr. Lowsley began his presentation with moving pictures of two of his operations. Among the operations discussed were those for urinary incontinence, incontinence of urine and feces, undescended testicles and paralysed bladder. The indications of the various prostatectomies were discussed with the indications for each.

Dr. Lowsley closed his presentation by answering questions from the floor.

During the business meeting, Dr. Miles S. Winder of Asbury Park, was elected to full membership, and Dr. Robert Barnett and Dr. Samuel Rubin of Asbury Park were elected to associate membership.

Other new business included discussion of a plan to present to certain osteopaths the privilege to attend the county society meetings. Dr. James Pregnall, chairman of the nominating committee, presented the following names. President-Elect—Harry Brindle, M.D. (one year term); Reporter—Lester A. Barnett, M.D., (one year term); Board of Censors—Kenneth Brown, M.D. (five year term); Delegates to the State Society—(three year term), William G. Herrman, M.D., Robert McTague, M.D.. Nominating Delegate — William Herrman, M.D., Alternate Delegates to State Society — Richard Demaree, M.D., William Heatley, M.D., Alternate Nominating Delegate—Daniel Featherston, M.D.

SOMERSET COUNTY

Homer E. Cook, M.D., Reporter

The regular meeting of the *Somerset County Medical Society* was held Thursday evening, April 8, 1948, at 8:30 p. m., in the Meeting Room of the Somerset Hospital Nurses Home, Dr. A. F. Mangelsdorff presiding in the absence of Dr. G. E. Barbour.

At the business session preceding the scientific portion of the program, the following resolution was read:

> The Somerset County Medical Society notes with sorrow the death of Dr. Augustus S. Knight, of Far Hills, N. J., on March 21, 1948.
>
> Doctor Knight was a member of this Society for many years and was well known to all his fellow physicians. He was an honest gentleman, courteous and kindly, a faithful friend and a worthy citizen. Be it therefore resolved:
>
> That the Somerset County Medical Society adopt these Resolutions, and
>
> That they be spread on its minutes and copies be sent to the family members and to the County newspapers.

The minutes of the previous meeting were read and approved.

Dr. A. L. Van Horn of Bernardsville, was elected to membership.

A letter from the American Association of Blood Banks was read and its requested endorsement was referred to committee. A letter concerning publishing of "Health Hints" was also read and members were appointed to notify local editors in their respective communities.

An announcement was made of the resignation of Dr. Albert W. Pigott, N. J. State Village, Skillman, and a testimonial dinner to be held in his behalf on the evening of April 26, at the Far Hills Inn, Somerville.

The scientific portion of the program was then opened. A movie on the *Vaginal and Cervical Smear*, prepared under the direction of Dr. Clair Folsome, and demonstrating the Papanicolaou Staining Technic and manner of collecting secretions, was presented by Mr. George Richardson of the Ortho Research Laboratories, Raritan. A discussion of the film followed. This was one of the first presentations of this film and it was very favorably received.

Adjournment followed an applause of sincere appreciation for the very current and illustrative film presented.

SUSSEX COUNTY

Katherine E. Stewart, M.D., Reporter

With Dr. G. W. Esty, pediatrician in charge of child guidance for the Bureau of Maternal and Child Health, as guest of honor, the *Sussex County Medical Society* held a very successful dinner meeting at the Cochran House, Newton, on May 4, 1948. The meeting, with 20 members present, was called to order by the president, Dr. Martin I. Kirschner.

A movie, *The Problem Child*, approved by the American Society of Pediatrics and donated by the Pet Milk Company, was shown.

During Dr. Esty's talk, which followed, the importance of the county societies availing themselves of the mental hygiene program for children, offered by the Bureau of Maternal and Child Health, was stressed. This program of mental health education is being given to the nurses and physicians attending *Baby-Keep-Well-Stations* of the State Department of Health; thus, it follows that the establishment of such stations in a county is the first prerequisite. Dr. Esty brought out that such a move must have the sanction of the County Medical Society and is in turn governed by that society and the local board of health in the community establishing the station. It was emphasized that no actual practice of pediatrics is allowed in these clinics and if such happens to occur the State Department of Health withdraws its services.

Dr. Esty's talk was stimulating, bringing forth a lively discussion among the members.

The business meeting followed, with a report by Dr. J. G. Coleman on the recent State Convention. Special mention was made of the changes of rates in the Medical-Surgical Plan of New Jersey. Dr. D. L. Spurgeon reported on the budget set up by the medical committee of the *Sussex County Branch of the American Cancer Society*. The plausibility of buying radium for the county from American Cancer funds was discussed. No definite conclusions were reached.

The nominating committee recommended the following panel of officers for 1948-49, all of whom were unanimously elected: *President*, Dr. Lester Eddy; *President-Elect*, Dr. Ewald Bergman; *Secretary*, Dr. Jack Caleca; *Treasurer*, Dr. John Scott, and *Reporter*, Dr. Robert Weinstein.

After Dr. Kirschner expressed his gratitude to the group for its cooperation during the past year, Dr. Lester Eddy, our new president, took the chair. He expressed the opinion that he would like to see a freer discussion of local problems of the society take place during his term. Adjournment followed the appointment of various committees by Dr. Eddy.

UNION COUNTY

E. M. Satulsky, M.D., Reporter

Under the chairmanship of DR. STANTON H. DAVIS, its president, the *Union County Medical Society* held its regular meeting on January 14, 1948, at the Elizabeth General Hospital in Elizabeth.

Dr. Royal A. Schaaf, president of the State Society, in a letter addressed to Dr. Davis, commended Dr. E. T. Yorke of Linden for his services as liaison officer for the State Society with the Veterans Administration. He expressed the hope that the County Society would assist Dr. Yorke in resuming his private practice as the liaison office has now been closed. Dr. Davis stated that everyone in the Society deeply appreciated Dr. Yorke's service and that he would be assisted in every way possible.

In a letter from Dr. W. O. Wuester, chairman of the Executive Committee of the American Cancer Society, Union County Chapter of the New Jersey Division, the County Society has been offered the use of a sound projection unit for the showing of educational films pertaining to the cancer field.

Dr. Griswold, chairman of the program committee, introduced the speakers of the scientific session. DR. W. ALAN WRIGHT of the Schering Corporation gave a *Report on Recent Advances in Hormone Therapy in Carcinoma.* DR. W. O. WUESTER of the James S. Green Tumor Clinic, Elizabeth General Hospital, discussed *Principles in the Treatment of Cancer of the Head and Neck* and DR. F. M. MASTROANNI of the Green Clinic gave a *Report on Nitrogen Mustard Therapy.*

The following applicants were elected to membership: DR. A. N. CONSTAD of Union; DR. J. A. CONNALLY of Plainfield; DR. L. A. DALLAM of Elizabeth; DR. W. H. DIEFENDORF of Summit; DR. L. C. GRIESEMER and DR. A. J. RANDOLPH of Roselle. DR. C. G. DARLINGTON of Plainfield was accepted for membership by transfer from the New York County Medical Society.

Merck & Company of Rahway was host to the *Union County Medical Society* at its regular meeting on March 10, 1948, and DR. STANTON H. DAVIS, the president, called the meeting to order at 9 p. m.

Dr. James M. Carlisle, Medical Director of Merck & Company, introduced the speaker of the evening, H. M. ZIMMERMAN, M.D., head of the division of laboratories at Montefiore Hospital, New York City, who presented a most instructive paper on "Recent Advances in the Treatment of Tuberculosis with Streptomycin".

Dr. Davis introduced Dr. James F. Norton, vice-president of The Medical Society of New Jersey who brought greeting from the State Society.

It was moved that the proposed amendment to the Constitution of the State Society be approved as recommended by the executive committee with the addition of the word "totally" before the word "disabled" in reference to veterans.

The recommendation of the executive committee was approved in regard to Senate Bill 1290—National School Health Services Act of 1947 and it was moved that telegrams be sent to Senators Hawkes and Smith and Congressman Case that the County Society disapproves of this bill. Members were also asked to write to Senators Hawkes and Smith and Congressman Case expressing their opposition to this bill which would authorize initial appropriation of ten million dollars for Children's Bureau to establish school health services for prevention, diagnosis and *treatment* of physical and mental defects and conditions.

The plan submitted by the Union County Tuberculosis and Health League to extend its x-ray facilities for chest x-rays to every adult in every community in the county on a rotating basis, the service to be one to four weeks' duration in any given area, depending on the size of the population, was approved. Patients with pathological findings would be referred to the family physician for further study and reports would be made only to the family physician. This service would be given to an individual only once a year and the price of each x-ray was placed at $1.50. The service will not interfere with the diagnostic clinics already established in the county.

The following applicants were elected to membership: DR. AARON J. KAYCOFF and DR. MANUEL J. ROWEN of Elizabeth.

DRS. M. L. GRISWOLD, P. J. KREUTZ and E. T. YORKE were elected to serve on the Nominating Committee. Dr. Griswold will serve as chairman.

WARREN COUNTY

Joseph C Humbert, M.D., Reporter

With DR. WALTER BOQUIST presiding, the regular bimonthly meeting of the *Warren County Medical Society* was held April 20, 1948, at the Warren Hospital, Phillipsburg. Applications for membership from DRS. DOREEN CORKE SHEFFIELD and JESSE SCHULMAN were received and referred to the board of censors. A letter from the State Medical Society about complaints of poor service at night and in emergencies was discussed, but it was felt the condition presented no great problem locally, and no action was taken.

The Hackettstown Red Cross Blood Donor Program was again brought before the Society. The Society, which had previously somewhat reluctantly approved the program, was on this occasion asked to actively sponsor it. Members criticized the program on the ground that the committee had no medical members, that the laboratory where the typing was to be done was not under medical supervision, and in general, that the Society was being asked to take responsibility without any control. The request was tabled and a committee, consisting of Drs. Frank Bartolini, Ralph Buchanan and Steven Stanowicz was appointed to confer with Red Cross representatives.

Warren Hospital has for a long time had a disproportionate amount of its limited bed space taken up by chronically ill aged patients from the county home. A committee appointed to discuss this problem with county authorities reported that at present there was no other place to care for these patients, and recommended that the State Department of Institutions and Agencies be approached about building a hospital for chronic diseases in the county.

Led by DR. A. C. ZUCK, there was a round table discussion of the problem of narcotic addition.

WOMAN'S AUXILIARY

ACCEPTANCE OF THE GAVEL

Mrs. Robert B. Walker, President

With a feeling of deep gratitude and indebtedness to my predecessors in office, I accept this gavel. To follow in the footsteps of so active and capable a person as Mrs. Mancusi-Ungaro merits this personal expression of deep appreciation.

In reviewing the history of the Auxiliary, I have noted that the work has gone steadily forward each year. It is essential to consolidate our efforts into one solid pattern of usefulness and cooperation with the Medical Society; to rationalize every step taken, so that each step is so firmly implanted in the pattern, the work each year will fit perfectly into the years that follow, with no misgivings.

The Medical Society recognizes the good we can do and the assistance we might give to them, if we remember that the Constitution and By-Laws were made for our own protection and that remaining within their requirements should be a privilege, not a hardship.

As members of the Auxiliary we should prove the worth of our organization to the Medical Society. We, as doctors' wives are an integral part of a noble and honored profession. It is our duty, in our homes, in our lives and in our contacts with people in other walks of life to hold the standard of that profession high, if we would point to others the paths of health and happiness.

It is important that all counties be organized. Before organizing them we must be assured that there is enough interest among the doctors and that they will give it their full support. When this is confirmed, it is imperative that we give these counties a firm foundation. Following organization the state officials and members of other component auxiliaries should show a special interest in these counties so that they may grow in strength, enthusiasm and determination.

A *News Bulletin* will be issued this year, designed to disseminate auxiliary news among all doctors' wives. This bulletin must necessarily have a modest beginning, but it is hoped that each successive year it will so increase in value that it will become an important part of our yearly work.

With a great deal of praise for the years that are past and with humble expectations for the year to come, I accept this gavel, not as a symbol of authority, but, as a symbol of the trust you have placed in me. May we have a happy year together, a year of friendliness, unity and progress.

PROGRAM 1948 - 49

Mrs. Robert B. Walker, President

1. Well informed, interested county auxiliaries.
2. Issue a news bulletin designed to disseminate auxiliary news and increase interest among all doctors' wives.
3. Study closely the health needs of each county and cooperate with the county medical society to improve these conditions.
4. Closer cooperation and understanding between the county medical societies and their auxiliaries.
5. Continue to promote increase in membership, until 100 per cent has been attained.
6. To be alert and study carefully all medical legislative enactments.
7. Help preserve the high standards of the medical profession in your community.
8. Acquaint every member with *Hygeia* and promote its distribution.
9. Incorporate a subscription to the A.M.A. auxiliary bulletin with the county dues so that each member may have an added interest in the work of the national organization and that of component auxiliaries.
10. Hold the second Conference Workshop early in the year.

AUXILIARY REPORTS

Atlantic County

Mrs. Matthew Molitch,
Chairman, Press and Publicity

A highly interesting meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on April 9, 1948, at the Hotel Traymore. The guest speaker of the evening was Mr. Leo T. Clark, special agent of the F.B.I., who spoke on "The Activities and Functions of the F.B.I."

Mrs. Edward H. Dyer, president, presided over the business meeting. The Auxiliary was highly honored by the presence of Mrs. Morris Fishbein, wife of the editor of the Journal of the American Medical Association.

The following slate for 1948-49 was read by Mrs. David B. Allman: President—Mrs. Harry Subin, President-Elect—Mrs. Louis Rosenberg, First Vice-President—Mrs. Clarence B. Whims, Second Vice-President—Mrs. Matthew Molitch, Secretary—Mrs. F. Rolfe Westney, Treasurer — Mrs. Irving C. Shavelson.

Mrs. Allman reminded the members of the coming convention of the New Jersey State Medical Society. Delegates from the Atlantic County Auxiliary are: Mesdames Harry Subin, Louis Rosenberg, Matthew Molitch, G. Ruffin Stamps, Edward H. Dyer, and Morton Major; alternates are: Mesdames F. Rolfe Westney, Lawrence A. Wilson, I. E. Leonard, Jr., Clarence Whims, William Hersohn, and Sidney Rosenblatt.

Bergen County

Reorganization Meeting
Mrs. Thomas H. McGlade
State Chairman, Press and Publicity

The reorganization of the *Woman's Auxiliary to the Bergen County Medical Society* took place at a luncheon and meeting, held at the Hackensack Golf Club, Oradell, on Wednesday, March 10, 1948, as guests of the Bergen County Medical Society.

Mrs. C. Chester Chianese, Organization chairman, introduced Dr. Rudolph C. Schretzmann, president of the Bergen County Medical Society. Dr. Schretzmann spoke of the benefit of the Auxiliary to the Bergen County Medical Society. He and the president-elect were hopeful that the Auxiliary would see fit to reorganize.

Mrs. Lodovico Mancusi-Ungaro, state president, gave an outline of the Auxiliary projects. This was followed by the reading of the objects of the Woman's Auxiliary, as set forth in the National Constitution, by the co-chairman of Organization, Mrs. Thomas P. McConaghy.

The following officers were elected: president, Mrs. Floyd E. Keir; president-elect, Mrs. Walter L. Jordan; first vice-president, Mrs. Edward V. Sexton; second vice-president, Mrs. Thomas A. Garrett; recording secretary, Mrs. Frederick Muller; treasurer, Mrs. Louis DeLuca; directors, Mrs. Ralph Gilady, Mrs. James T. York, Mrs. Edward J. Salva, Mrs. Philip S. Busicco, Mrs. Kenneth M. Delafrange and Mrs. Peter Minck, Jr.

The best wishes of the State Auxiliary were expressed by the members attending the meeting. They were: Mrs. Lodovico Mancusi-Ungaro, Mrs. Robert B. Walker, Mrs. Richard J. McDonald, Mrs. C. Chester Chianese, Mrs. Thomas P. McConaghy, Mrs. Bank S. Baker and Mrs. Joseph Mott.

Camden County

Mrs. Wilmer F. Burns
Chairman, Press and Publicity

A musical program featured the regular meeting of *The Woman's Auxiliary to The Camden County Medical Society* held March 2, 1948, at the home of Mrs. Harold K. Eynon, Haddonfield. Mrs. William Matteson, harpist, appeared as the guest artist. Dr. and Mrs. William T. Read, the latter being a new member of the group, played duets on the piano and the Auxiliary Chorus rendered several excellent selections.

Mrs. Arthur G. Pratt, president, conducted the business meeting during which the election of officers took place and delegates to the convention were appointed. Mrs. Arthur J. Casselman, chairman of the nursing scholarship committee announced that girls who are interested in taking advantage of the fund should apply to her or the directors of the Schools of Nursing at West Jersey or Cooper Hospitals.

Mrs. A. Girton Kinney, membership chairman, introduced nineteen new members for whom a reception was held.

Essex County

Mrs. Asher Yaguda,
Chairman, Press and Publicity

Mrs. Donald M. Caldwell, public relations chairman of the *Woman's Auxiliary to the Medical Society of Essex County,* presented an all-day program of medical topics to an audience of key organization men and women of the county on April 2, 1948. The morning session was on child health and covered the emotional and appetite problems of children as well as an excellent presentation of "Rheumatic Heart Disease in Children". The Essex County Blood Bank was explained by its founder, Dr. William Crecca. Dr. Frederic J. Quigley, with Miss Grace Freeman and Mrs. Minna Greenbaum, New Jersey legislators, discussed pending medical legislation.

It was interesting to note that during the morning session there were present a goodly number of the lay members of the Essex County Council for Improvement of School Health Services. This seems to prove that our council members are taking their responsibilities seriously and are seeking information on child health.

A further activity in public relations was the joint meeting of the Contemporary Club members with our organization. This is a yearly custom. An excellent program on "Various Phases of Cancer" was arranged, with two out-of-county physicians, and one Essex County physician comprising the panel. There was an excellent attendance.

Our "Check and Double Check" booklets have

gone the rounds through the membership, and are now in the hands of the public relations committee for placement in lay organizations.

We held our annual dance on March 31, and it was a great success both from a standpoint of enjoyment and the mundane accomplishment of making our Auxiliary treasury solvent for some time to come.

Hudson County

Mrs. Morris Bresev,
Chairman, Press and Publicity

The Woman's Auxiliary to the Hudson County Medical Society held its regular meeting on April 5, 1948, at the Young Women's Christian Association Building, Jersey City. The meeting was called to order by the president, Mrs. William Gleeson.

Mrs. Samuel Scott reported that the dinner dance held March 31, 1948, at the Condor in Livingston, N. J., was a success.

At a special meeting held March 15, 1948, a majority voted in favor of the proposed change in our Constitution. The amendment now reads:

> "The term of office, except that of the treasurer, shall be for one year, and no officer shall be eligible for office for two consecutive terms."

Since this amendment is not retroactive, those now holding office shall continue in their various capacities through May 1949 when their term will expire.

Mercer County

Mrs. Joseph R. Burns,
Chairman, Press and Publicity

Mrs. Ernest F. Purcell, president, welcomed representatives of women's organizations to the second annual Public Relations Meeting and Tea sponsored by the *Woman's Auxiliary to the Mercer County Medical Society* on Wednesday, March 3, 1948, at the Medical Building on West State Street.

Dr. George N. J. Sommer, Jr., president of the Mercel County Tuberculosis and Health League was principal guest speaker. His topic, "Tuberculosis Problem Today", was very timely in view of the new school health plan sponsored by the State Medical Society.

Dr. C. Chester Chianese, president of the Mercer County Medical Society, and Mrs. Lodovico Mancusi-Ungaro, state president of the Auxiliary, spoke briefly on socialized medicine.

Greetings were extended by Dr. William C. Carroll, advisor to the Auxiliary.

Monmouth County

Mrs. Irving Baer,
Chairman, Press and Publicity

The monthly meeting of the *Woman's Auxiliary to the Monmouth County Medical Society* was held Tuesday, February 17, 1948, at the American Hotel in Freehold. Mrs. George McDonnell was hostess.

Mrs. Norman Nathanson, president, reported on the January 12th executive meeting of the New Jersey Medical Society Auxiliary held in Trenton. Excerpts of the talk given by Mrs. Bruce Shaefer, national legislative chairman, were given. The members were urged to become well informed on subjects pertaining to the current legislative bills now in Congress, that will affect the health and welfare of the entire nation.

A letter was read from the New Jersey health commissioner of education, thanking the Auxiliary for assistance in organizing a County Health Council for the improvement of school health services.

Another letter from Miss Elizabeth Hynes, Superintendent of Allenwood Hospital, thanked the Auxiliary for the Christmas donation of $100 to be used toward the purchase of a television set for their patients.

Members were reminded of the State Convention being held April 27, 28 and 29, at Haddon Hall, Atlantic City.

Mrs. Stephen Casagrande, legislation chairman, distributed leaflets on the Medical-Surgical Plan of New Jersey. This plan was explained thoroughly by Mrs. Casagrande.

A donation of $5 will be sent to the Intercultural Committee of Asbury Park in response to their request for aid in paying the needed expenses to conduct their yearly Brotherhood Contest throughout the county schools.

Mrs. Nathanson accepted the appointment of New Jersey delegate to the National A.M.A. Convention in June, in Chicago. She also will attend the annual New York Medical Society Auxiliary meeting in May as a guest.

Mrs. Baer announced space has been allotted in the monthly Medical Society bulletin for Auxiliary news and announcements. She will also purchase monogramed paper.

Mrs. A. George, Hygeia chairman, reported that the magazine *Hygeia* has been successfully installed throughout the county high schools by gift subscription.

A telephone committee was appointed in response to a direct request of the Medical Society. Their duty will be to call all society members to remind them of their meetings and to inform them about speakers and their respective topics.

A nurses' scholarship fund was discussed; also financial aid to Allenwood Hospital and the Brisbane School for children. These plans will be submitted to the Medical Society Advisory Board for consideration and approval.

Ocean County

Mrs. Harvey Rinzler,
Chairman, Press and Publicity

A special committee of the *Woman's Auxiliary of the Ocean County Medical Society* met with the local school doctors at Paul Kimball Hospital, on March 22, 1948, to launch a new program of school health service. Mrs. Alice Taylor, president of the Ocean County Auxiliary, presented the plan, with the assistance of Mrs. Mabel Dodd. Intended to improve the health of our school children by making their periodic physical examination in school more thorough, the plan originated with the State Medical Society and is already functioning in nearly all the other counties of New Jersey. To insure the accomplishment of the program, a council will be set up consisting of lay people, school nurses,

school doctors, and representatives of the Board of Education. Mrs. Asher Yaguda, of the State Auxiliary, and a member of the State Medical Society will discuss the program for those people involved at an April Conference in Ocean County.

The school doctors who attended the first meeting on March 22 were: Drs. Gove (Brant Beach), Dodd (Beach Haven), Pecora (Farragut Academy), Van Der Sande (Seaside), Carmada (Lakehurst), and Talmadge (Lakewood). Representatives of the Auxiliary were Mesdames Alice Taylor, Jean Goldstein, Mabel Dodd, Evelyn Rinzler, and Emma Pecora.

Passaic County

Mrs. Joseph E. Mott,
Chairman, Press and Publicity

The regular meeting of the *Woman's Auxiliary to the Passaic County Medical Society* was held on March 15, 1948, at the home of Dr. and Mrs. Randazzo of Passaic, with Mrs. Albert G. Markel presiding.

Reports were given by the chairmen of all committees. Mrs. Earl L. Warren announced that her committee has just completed 350 cancer dressings. The public relations report was read by Mrs. Richard J. McDonald in the absence of the chairman. This report was a complete summary of the recently formed Passaic County Council for the Improvement of School Health Services; the next meeting of this Council is to be held on March 24. Also contained in this report was the announcement of the open meeting of the Auxiliary to which the public is invited. The subject will concern itself with the health of children.

Mrs. A. M. Schultz gave the report on post war planning, and as vice-chairman of the Nurse Scholarship gave a comprehensive outline of the work of that group.

Mrs. Thomas F. Reilly discussed the plan of the City of Newark and Mrs. R. R. Goldenberg spoke on the Blue Cross Plan.

Mrs. Joseph E. Mott reported for press and publicity.

The membership chairman, Mrs. James S. Gallo, introduced the following new members: Mrs. B. M. Krugman, Mrs. Aaron Weiner, Mrs. John Ianacone and Mrs. S. C. Yachnin, who were graciously welcomed by Mrs. Markel.

Mrs. David Levine, chairman of the card party to be held on May 3 at the Paterson Woman's Club for the benefit of the Nurse Scholarship Fund, gave a complete report on the activities of the committee, announced the prizes and distributed the tickets for the card party.

The chairman of the Nominating Committee, Mrs. R. J. McDonald presented the following slate: President—Mrs. Peter J. De Bell, Passaic; First Vice-President—Mrs. Theodore K. Graham, Paterson; Second Vice-President—Mrs. Earl L. Warren, Paterson; Treasurer—Mrs. E. J. Hatem, Clifton; Secretary—Mrs. R. R. Goldenberg, Paterson.

Following the business meeting, Mrs. Peter J. De Bell introduced the guest speaker, Rev. George Howard, Pastor of the Unitarian Church in Hackensack, who spoke to the members on the subject "Am I a Normal Person".

Salem County

Reorganization Meeting
Mrs. Thomas H. McGlade,
State Chairman, Press and Publicity

A most interesting reorganization meeting of the *Woman's Auxiliary to the Salem County Medical Society* was held on Tuesday, April 12, 1948, at the Dupont-Pennsgrove Country Club, following a luncheon.

Mrs. Thomas P. McConaghy, co-chairman of Organization, welcomed those present and thanked the Salem County members for their splendid cooperation in bringing about a successful meeting. She appointed Mrs. Banks S. Baker, recording secretary of the State Auxiliary, as temporary chairman of the meeting and asked Mrs. C. Chester Chianese, chairman of Organization, to read the Objects of the Auxiliary.

Mrs. Asher Yaguda, past president and chairman of Public Relations, was asked the purpose of the existence of an Auxiliary. She stated it was an opportunity to extend the aims of the medical profession to all organizations interested in health education, the work and material having had the advance approval of the Medical Society. She added that the Auxiliary acts as the official source of health education for women's lay organizations.

The state president, Mrs. Lodovico Mancusi-Ungaro, stressed the necessity of organizing an Auxiliary in a small county and working together for the benefit of a great profession. She spoke of the friendship the Auxiliary offers to women of responsibility. An opportunity is afforded us to tell groups the viewpoints of organized medicine, with reference to bills in legislation and the Medical-Surgical Plan. It is important to obtain the permission of the Medical Society before starting on any venture.

After a lively discussion as to the aims and purpose of an Auxiliary, a motion was made to reorganize. This was unanimously passed by the fifteen members and the objects of the Auxiliary accepted.

Election of officers was then in order and the following were elected: president, Mrs. Frank L. Perry; president-elect, Mrs. R. Louis Silverman; first vice-president, Mrs. Maurice Chesler; second vice-president, Mrs. C. Spencer Davison; recording secretary, Mrs. William H. Miller; treasurer, Mrs. David W. Green; directors, Mrs. August Jonas, Mrs. H. D. Wolf, Mrs. J. P. Griffin, Mrs. Isadore Lipkin and Mrs. Harry F. Suter.

Mrs. Frank L. Perry gave a short acceptance speech and commented on the importance of health education to the profession.

Mrs. Lodovico Mancusi-Ungaro congratulated the newly organized Auxillary and expressed her gratitude to Dr. William H. Miller, president of the Salem County Medical Society and the president-elect, Dr. David Neander.

BOOK REVIEWS

Sexual Behavior in the Human Male. By Alfred C. Kinsey, Wardell B. Pomeroy, and Clyde E. Martin, Department of Zoology, Indiana University. Pp. 804. Philadelphia and London, W. B. Saunders Company, 1948. $6.50.

The publication of this book precipitated a furor throughout the country. The lay public, the medical profession, and the ministry have exhibited a consuming interest. Examination of the book quickly reveals the reason. It is an exhaustive, somewhat exhausting, study and analysis of the sexual patterns and sexual outlets of the human male from infancy to old age. Facts were obtained from interviews and case histories of 12,000 persons. The external influences on sexual conduct (age, marital status, social level, religious background, etc.) are considered. Then comes an analysis of all the methods of sexual activity such as masturbation, nocturnal emission, prostitution, homosexuality, and sodomy.

The only male whose sex behavior is not considered in this book is a dead one. The universality of its appeal therefore, can be readily understood. However, readers who anticipate pornographic, erotic information or stimulation will be disappointed. The book is compiled in an ultra-factual and statistical manner and is meant not for casual reading but for careful study.

Throughout the volume significant variations are emphasized between the sexual activity (both qualitative and quantitative) of males in the lower social and educational levels compared with males of the higher social and educational levels. The chapters on "Heterosexual petting", "Pre-marital intercourse", "Marital intercourse" point out these differences very clearly. These chapters are especially recommended for reading by the physician for enlightenment of many of the adjustment and "psychosomatic" problems so frequently calling for his help.

Mortimer Weiss, M.D.

A Text-Book of Pathology. By E. T. Bell, M.D., Prof. of Pathology, Univ. of Minnesota. 910 pp., 500 illustrations and 4 color plates. Lea & Febiger, 1947, Philadelphia. $10.00.

This textbook for the medical student covers an amazing variety of subjects including even a short paragraph on the effects of an atomic blast. Especially comprehensive are the discussions of the pathology of vitamin deficiencies and tropical diseases. At the end of each section are references to the literature. The chapters on tumors and on diseases of the blood are excellent. There are many illustrations including diagramatic sketches and photographs of gross and microscopic material.

While the book is not designed for the qualified pathologist, the clarity and brevity of its discussions and the variety of its subject matter make it of intimate interest both to the student (as a textbook) and to the general practitioner as a useful reference and review of pathology.

William Lipstein, M.D.

Dermatologic Clues to Internal Disease. By Howard T. Behrman, M.D., Assistant Clinical Professor of Dermatology, New York University College of Medicine. Pp. 165. New York. Grune & Stratton, Inc., 1947. $5.

Dr. Behrman's book makes pleasant reading and may be a revelation in exposing the close relationship between the syndromes of internal medicine and surgery with cutaneous manifestations. Although he adequately deals with the more common dermatoses related to non-dermatologic conditions, the author has undoubtedly not intended his treatise to be encyclopedic. He has neatly organized his material into a monograph well worth adding to the library of any physician no matter what his branch of practice.

Edmond Edelson, M.D.

Aging Successfully. By Dr. George Lawton. Psychologist. Pp. 266. Columbia University Press, New York, 1946.

This psychologic approach to the problems of maturity, is a well balanced, informal treatise on the expanding field of geriatrics. Much of the material is aimed at the mature person in the form of advice on matters concerning retirement, goals, interests, philosophy and love. The author uses anecdotes and examples liberally and lists "Do's and Don'ts" and a "Bill of Rights" for the aged. He emphasizes the increasing need for enlightened and modern facilities in the way of nursing and convalescent homes.

The book is practical and may be read profitably by the layman as well as physicians, social workers, et cetera. Its language is non-technical and it should have a large appeal to the interested.

Joseph A. Pinto, M.D.

Overcome Stammering. By Charles Pellman. 160 pages. Beechhurst Press, New York, 1947. $3.00.

The author of this slender volume is a lay "correctionist" and not a physician, teacher or psychologist. He advises treatment of stammering by speech drill, and takes issue with the psychiatrist's concept of stammering as a manifestation of emotional conflict. For instance, Pellman quotes Dr. J. S. Greene as saying "The symptom of stuttering should not be isolated but should be considered as an expression of the whole organism of a disintegrated individual". While most physicians would accept this as plain common sense, Pellman, dismisses it as "a spectacular assumption". As a matter of fact Pellman is wedded to the naive theory that the nervousness which the stammerer shows, is the *result* of his stutter.

As a whole, the volume represents amateurish and superficial advice to treat the symptom of stammering by speech exercises. It will be useful to those persons who would treat crying spells by applying astringents to the eyelids.

Arnold M. Kallen, M.D.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **June, 1948** **No. 6**

FOR the first time in the long history of tuberculosis there is a drug which, if used in certain forms of tuberculosis at the proper time and in suitable dosage, will favorably influence the course of the disease. In streptomycin physicians have not a specific but a new weapon to be added to those they are already using so effectively.

STREPTOMYCIN IN TUBERCULOSIS

Although attempts to attack tuberculosis by chemotherapeutic means are as old as our knowledge of the disease, it was not until 1940 that Feldman, Hinshaw and Moses reported that promin had a striking effect on tuberculosis induced in guinea pigs. Attempts to use this and a few other drugs clinically followed. The results were suggestive but never fully convincing, possibly because the sulfone compounds were found to be too toxic in the dosage required for treatment of human beings.

From the first, the antibiotic *streptomycin* gave great promise as an agent for suppressing tuberculosis. In early reports Schatz and Waksman noted that a human strain of Mycobacterium tuberculosis was sensitive to streptomycin *in vitro* and further investigations by Feldman and Hinshaw proved conclusively that streptomycin would arrest and at times even apparently eradicate well established tuberculosis in the highly susceptible guinea pig.

The clinical use of streptomycin for tuberculosis was begun in December, 1944, and has been used by the author and his colleagues in more than 100 cases of tuberculosis of various types. At present (March, 1948) more than 500 additional patients are being treated with streptomycin at selected institutions under the auspices of the American Trudeau Society as well as a large number elsewhere.

In all discussions of the therapeutic possibilities of streptomycin in tuberculosis the situation must be viewed in proper perspective. The ability of streptomycin to suppress the disease is unique and at times apparently remarkable. The limitations of streptomycin are just as real. Because of certain toxic potentialities, its inadequacy in some clinical situations, and the expense of prolonged periods of treatment, the indiscriminate use of streptomycin in the treatment of tuberculosis must be discouraged.

The use of streptomycin in tuberculosis is indicated in all forms of *hematogenic disease*, including generalized miliary tuberculosis and meningitis, the prognosis of which has hitherto been regarded as hopeless. Of 12 patients who had disease of this type and were treated with streptomycin at the Mayo Clinic, four are living after six to 12 months. In treating tuberculous meningitis it is imperative that streptomycin be given both parenterally and intrathecally and as early as possible in the course of the disease.

Pulmonary tuberculosis suitable for treatment with streptomycin includes recent lesions of bronchiogenic dissemination, exudative lesions, and all recent but rapidly progressive tuberculosis which is not likely to be controlled by the usual methods. Pulmonary tuberculosis has been treated satisfactorily by daily doses of from one to three Gm., administered parenterally, for a period of from two to six months. Clinical improvement is noted early and can usually be demonstrated roentgenographically within one to two months. Cavities, especially if thick walled, are apt to remain patent. Sputum findings are changed from positive to negative in about half of the cases of far advanced pulmonary tuberculosis.

The patient whose pulmonary tuberculosis has improved during treatment with streptomycin usually continues to improve after this treatment is discontinued.

The use of streptomycin in pulmonary tuber-

culosis possibly is indicated as an adjunct to surgical procedures, such as lobectomy, pneumonectomy and even thoracoplasty. Streptomycin has been used with notable success in tuberculosis of the hypopharynx, larynx and tracheobronchial tree. Tuberculosis draining sinuses have responded well to treatment with streptomycin, even those of long duration.

Streptomycin therapy has shown encouraging results with cases of tuberculosis of the alimentary tract and peritoneum and tuberculosis of bones and joints.

Streptomycin has been somewhat disappointing in the treatment of some cases of tuberculosis of the genitourinary tract. Marked symptomatic improvement occurs in more than 50 per cent of such cases and the degree of tuberculous bacilluria usually is reduced. It is not a substitute for surgical procedures in cases of unilateral renal tuberculosis.

Among tuberculous conditions in which streptomycin is not indicated are included all cases in which satisfactory progress is made on a regimen consisting of the usual therapeutic measures. This category would include most cases of minimal pulmonary tuberculosis. The potential toxicity of streptomycin appears to be sufficient to deny the drug to patients who can make a satisfactory recovery without it.

At present chronic fibrocaseous pulmonary tuberculosis is not considered suitable for treatment with streptomycin except in combination with surgery nor are terminal cases of destructive pulmonary tuberculosis except as a palliative procedure. Treatment of tuberculosis empyema with streptomycin has been disappointing.

It must always be emphasized that treatment with streptomycin is not a substitute for rest in bed and sanatorium care, which are still fundamental in the treatment of tuberculosis. It cannot be expected to supersede collapse therapy and other surgical procedures when these are indicated.

Our knowledge of streptomycin is still in a state of flux. Its ultimate place in the treatment of some types of tuberculosis will be determined only after the extensive clinical investigation now under way is complete. Experience with this antibiotic agent has proved that tuberculosis is a disease amenable to antibacterial therapy and it is hoped that other usable agents will be forthcoming.

Streptomycin in Tuberculosis, H. Corwin Hinshaw, M.D., Marjorie M. Pyle, M.D., and William H. Feldman, D.V.M., The American Journal of Medicine, May, 1947.

Suggested Reading:

1. Rep. of Council on Phar. and Chem., J.A.M.A., No. 8, 1947.
2. Am. Rev. Tuberc., Nov. and Dec., 1947. 21 articles.
3. North Carolina M. J., Nov., 1947. 3 articles.
4. Nat. Tuberc. A. Bull., Dec., 1947.
5. Ann. Int. Med., May, 1945.
6. Ann. Int. Med., Nov and Dec., 1947.

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1. *Editorial: The Problem of Amebiasis, J.A.M.A.* 134:*1095 (July 26) 1947.*
2. *Wilbur, D. L., and Camp, J. D.: Amebic Disease of the Cecum: Clinical and Radiological Aspects, Gastroenterology* 7:*535 (Nov.) 1946.*
3. *Morton, T. C. St. C.: Diodoquin for Chronic Amoebic Dysentery in Service Personnel Invalided from India, Brit. M.J.* 1:*831 (June 16) 1945.*

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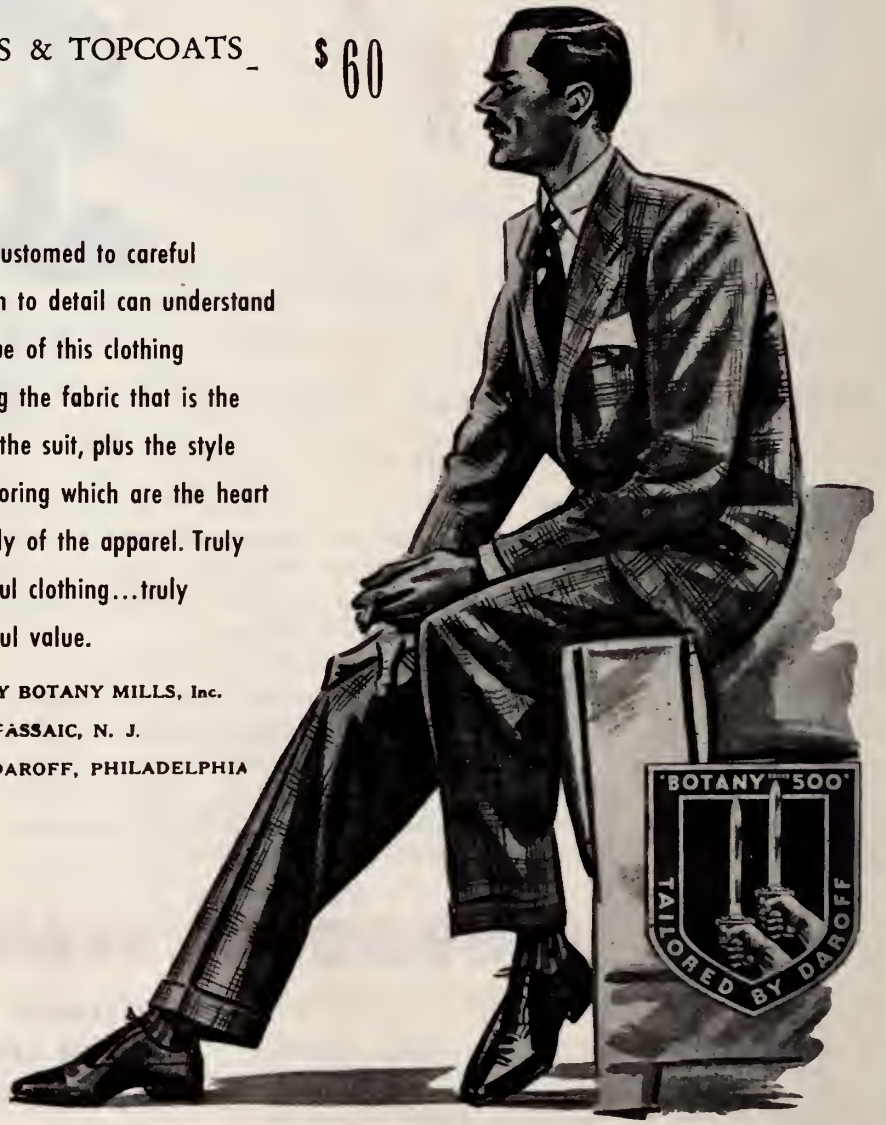
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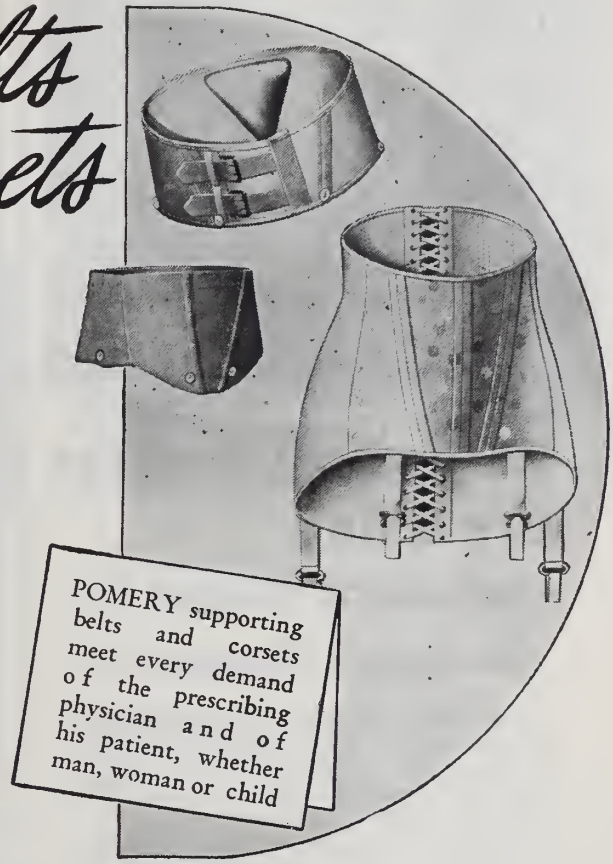
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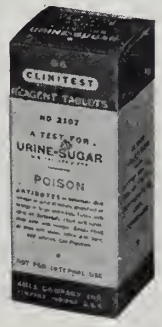
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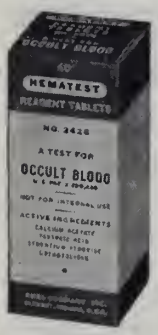
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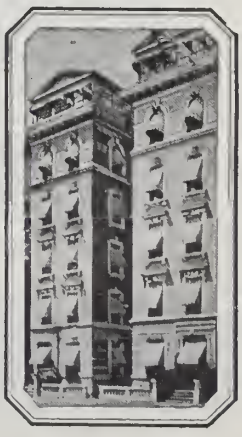
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OF

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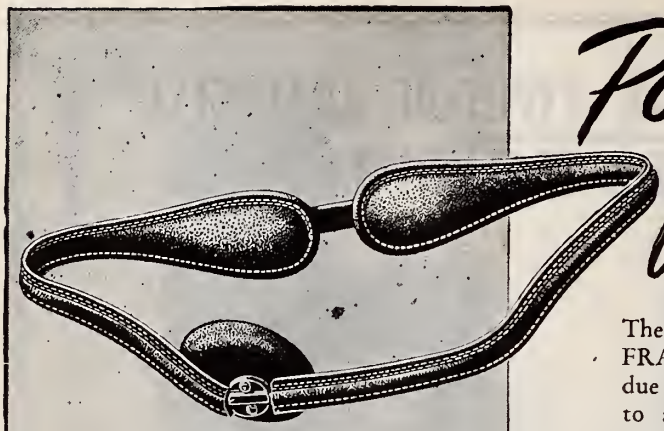
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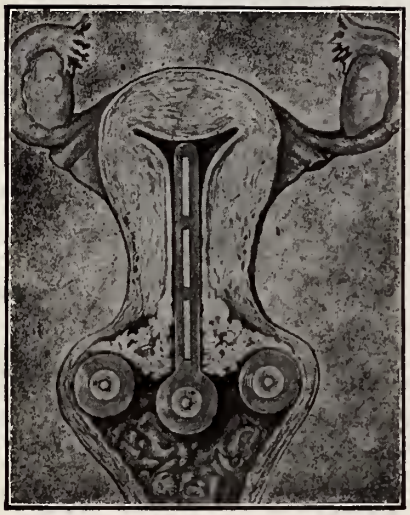
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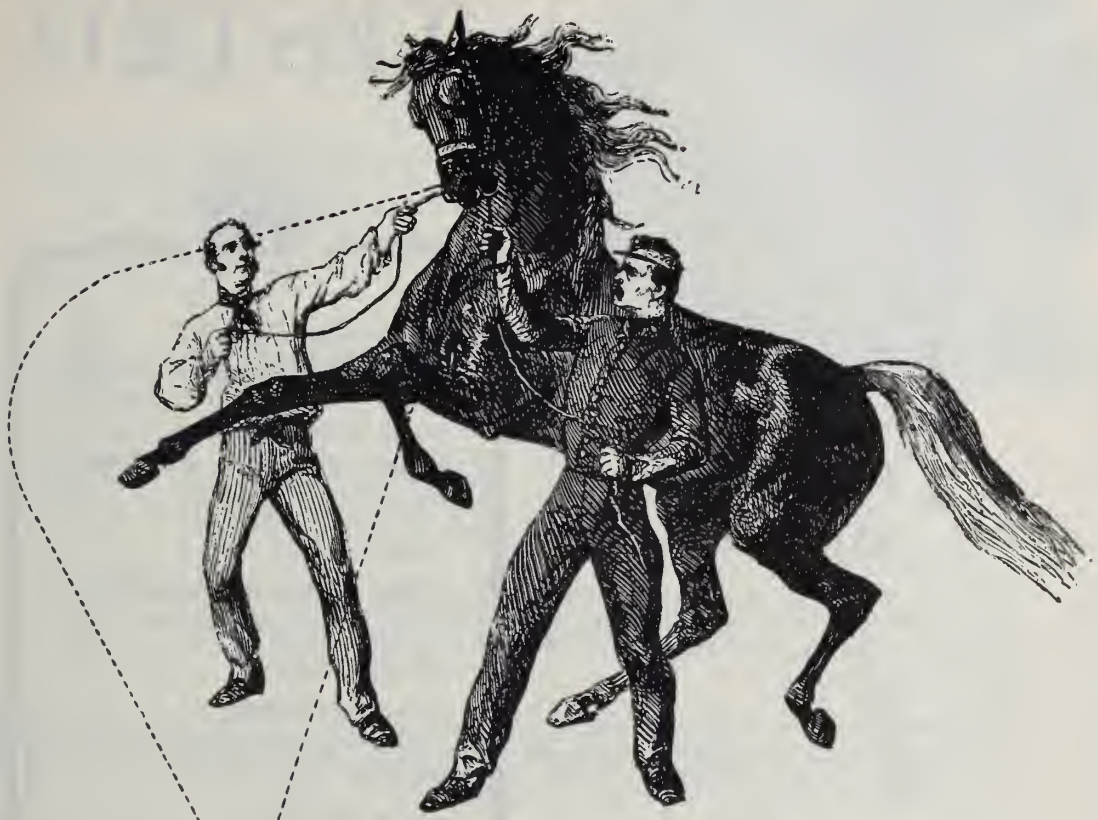


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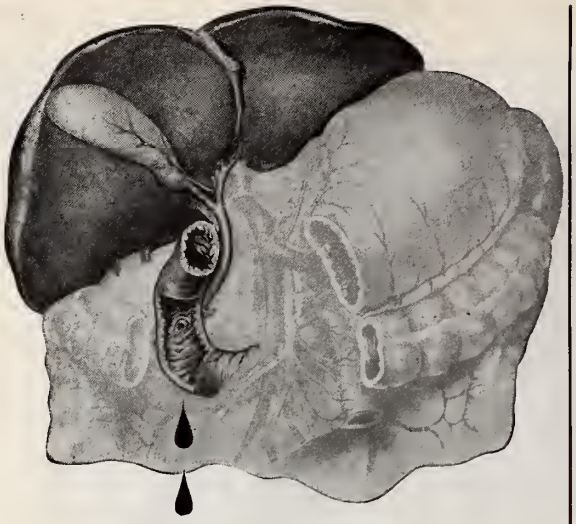
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This study again emphasizes the need for a diet rich in biologically complete protein during the latter half of pregnancy. In this manner, the physiologic loss of nitrogen at term can be compensated, avoiding negative nitrogen balance. A high protein diet has the further advantage of producing a more copious milk supply.

In another recent publication,[2] the prevention of the toxemias of pregnancy by dietary means was stressed. Foremost among the measures recommended was a diet rich in high quality protein to assure nitrogen balance.

Meat is an outstanding source of protein in the dietary of pregnancy and lactation for these four reasons: (1) It is notably rich in protein, from 17 to 20 per cent of its uncooked, and from 25 to 30 per cent of its cooked weight; (2) The protein of meat, regardless of cut or kind, is biologically complete; (3) The appetite appeal of meat is high, and (4) All meat is of excellent digestibility—from 96 to 98 per cent.

1 Stuart, H.C.: Effects of Protein Deficiency on the Pregnant Woman and Fetus and on the Infant and Child, New England J. Med. 236:507 (Apr. 3) 1947.

2 Zeigler, R.F., Jr.: Pre-eclamptic Toxemia of Pregnancy. North Carolina M. J. 8:655 (Oct.) 1947.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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propionate-caprylate compound

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Propionic acid	2.7%
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Zinc caprylate	5%

1 oz. tubes

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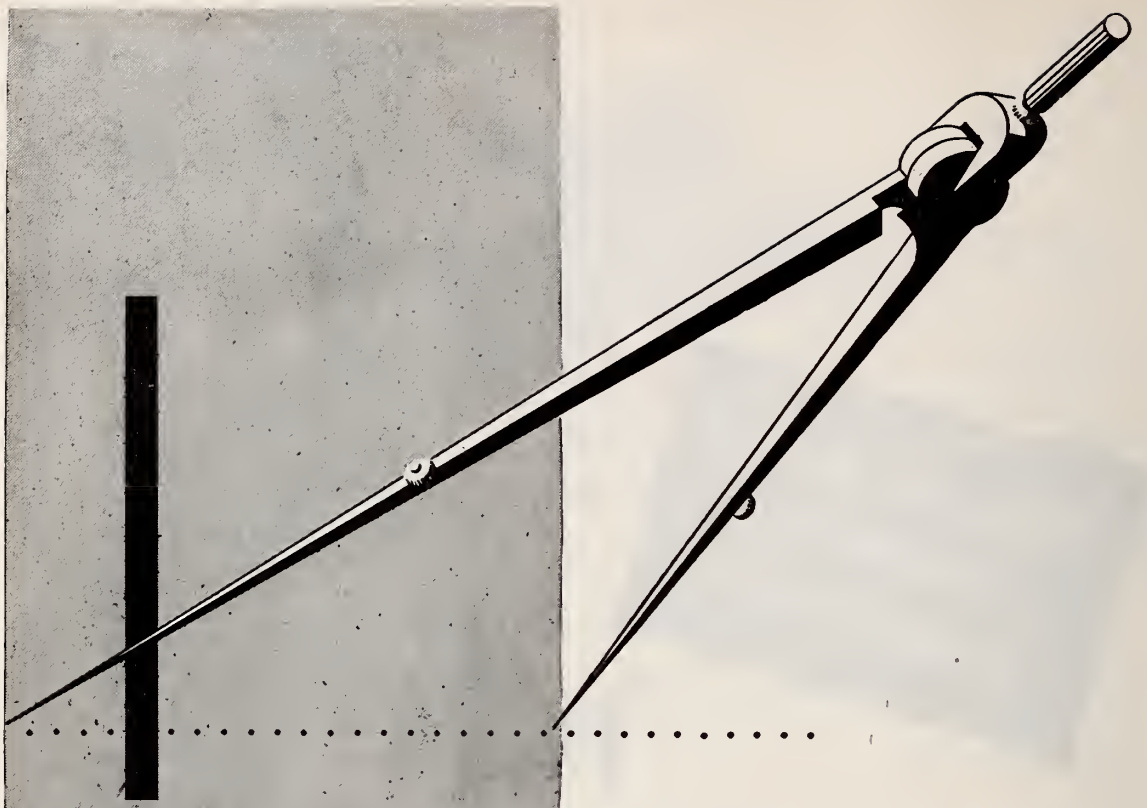
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Propionic acid	0.25%
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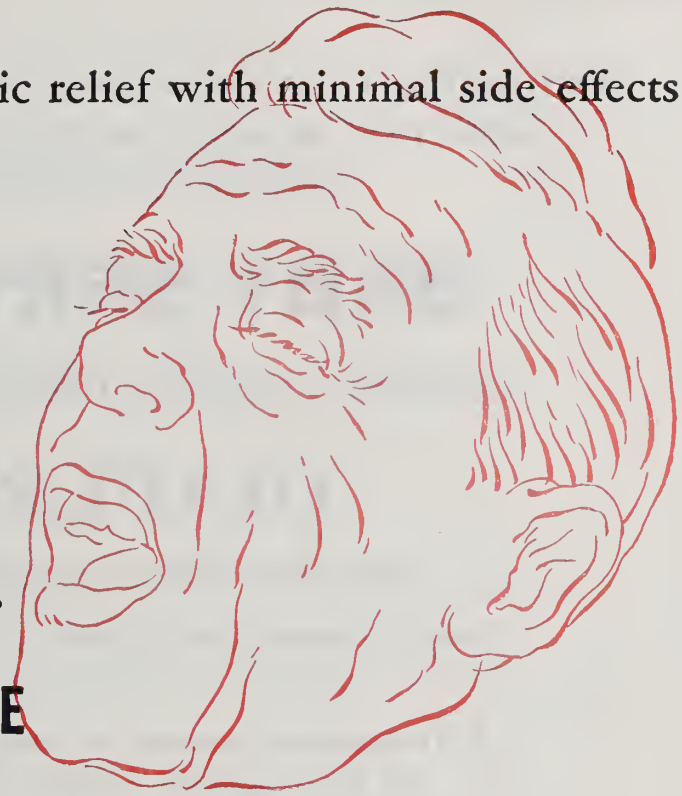
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1. ARBESMAN, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. LOVELESS, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. BERNSTEIN, ROSE and FEINBERG: *Ill. Med. Jl.*, 92: 2, 1947.
4. OSBORNE, JORDON and RAUSCH: *Arch. of Derm. & Syph.*, 55: 318, 1947.

PYRIBENZAMINE SCORED TABLETS, 50 mg., bottles of 50, 500 and 1000.
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1. Downing, J. G., Hanson, M. C. and Lamb, M.: Use of 5-Nitro-2-Furaldehyde Semicarbazone in Dermatology, J.A.M.A. *133*:299, 1947 • **2.** Robinson, H. M. and Robinson, H. M., Jr.: The Comparative Values of Some New Drugs in the Pyodermas, South. M. J. *40*:409, 1947 • **3.** Miller, J., Rodriquez, J. and Domonkos, A.: Evaluation of Penicillin in Topical Therapy, New York State J. Med. *47*:2316, 1947 • **4.** McCollough, N. C.: Treatment of Infected War Wounds with a Nitrofuran. Indust. Med. *16*:128, 1947.

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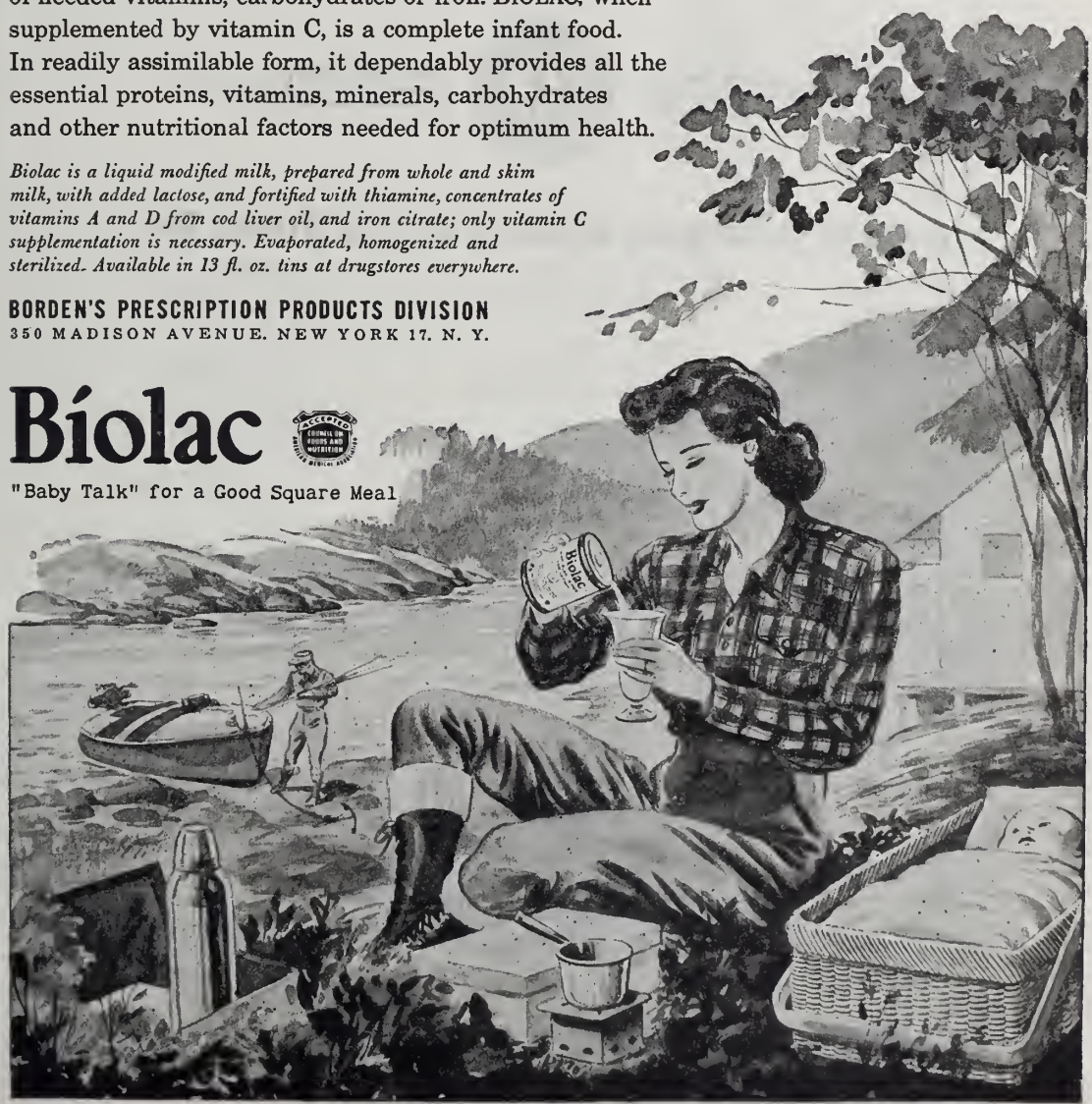
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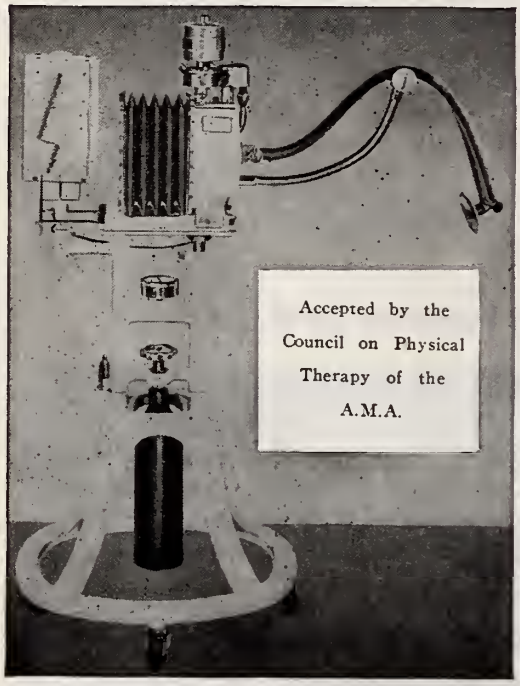
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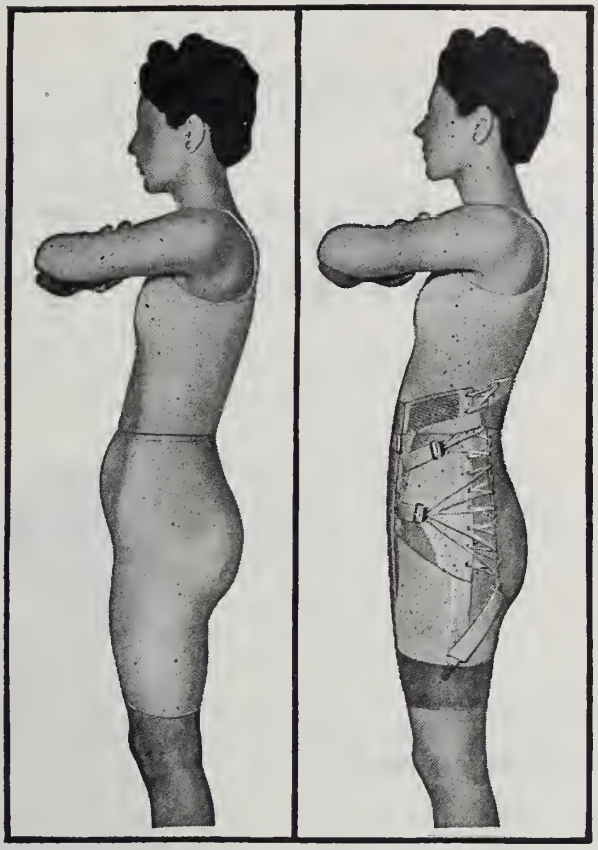
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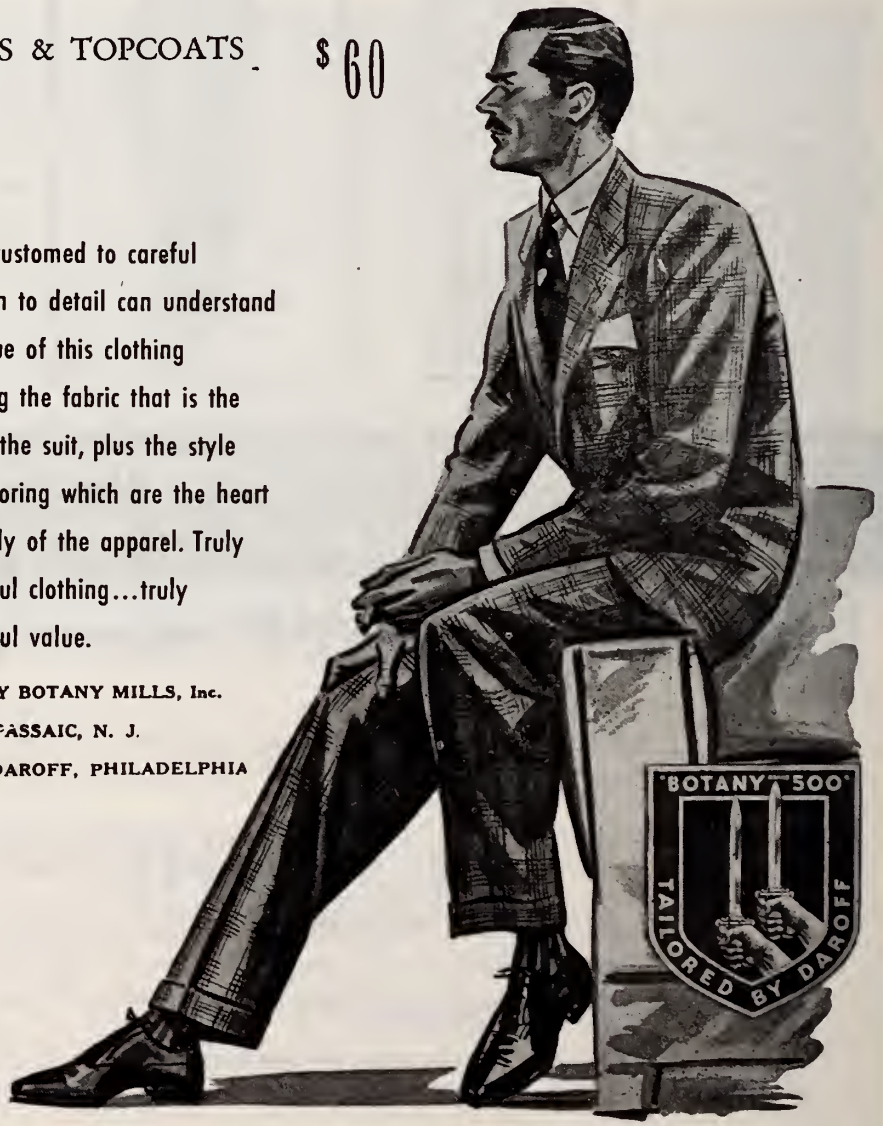
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THE NEW HEALTH COMMISSIONER

The Medical Society of New Jersey was one of the accoucheurs at the birth of the State Health Department. The Department sprouted from a Birth and Death Registry, established just a century ago. And the Registry was originally compiled by our Society from the reports of sextons on births and funerals. At the insistence of the Medical Society, the state took over the function in 1848, and thus laid the foundation for a state department which has grown mightily and which was conspicuously rejuvenated last year when a new law immeasurably strengthened the Department. The new Commissioner will combine in one person many of the powers previously distributed between the old Director and the old State Board of Health.

It is thus, for both historical and practical reasons, that the Society has an intimate interest in the selection of the Commissioner who will wield so much authority over health activities in New Jersey. We note with gratification the nomination and confirmation of Dr. Daniel A. Bergsma, a native of our state and a member of our Society, to serve as the first Commissioner in the reorganized Department. Dr. Bergsma's professional background gives assurance of both technical and executive competence. His exceptional Army record, in a difficult field of public health, is evidence of his effectiveness as an Administrator. In some areas of the country, there has developed friction between private practitioners and public health administrators. For the most part, our own state has been free of any such difficulty. Indeed, the recent election of Mr. MacDonald as an honorary member of The Medical Society of New Jersey is an unmistakable symbol of the close relationship between the Department and our Society. Needless to say, we wish Dr. Bergsma well. We anticipate his support and pledge him our own in our joint efforts for better health for the people of New Jersey.

PREVENTIVE MEDICINE AND THE PRIVATE PRACTITIONER

To his own private patients, every practitioner can be a personal health officer. Such a program would earn goodwill and thwart governmental tampering with the doctor-patient relationship. Preventive medicine is something that every physician likes to lecture about; but it is a project that few doctors can put into practice in the day by day operation of an office. Yet an imaginative physician may well build a career for himself as an expert in the field. Perhaps he could be called a "preclinician". He would need specialized knowledge—and such a body of knowledge is available in numerous courses and text-books. He might need specialized diagnostic equipment — including practical examination forms, to be thoroughly filled out on all patients. A preventive medicine practice would mean fewer emergencies, a more stabilized fee structure, more regular working hours.

It is a job which would require the participation of outside agencies. Perhaps life insurance companies may be persuaded to offer reduced premiums to subscribers who submit certified and adequate annual physical examinations. Perhaps public schools will turn more to the practitioner who has earned a reputation in the field of personal hygiene and preventive medicine. The cooperation of the large voluntary and public health agencies can certainly be anticipated.

We keep saying with monotonous regularity that it is easier to treat early diabetes than the later stages of the disease, easier to keep in good shape the heart of the patient examined before decompensation has set in; easier to save life when the carcinoma is detected before metastasis has occurred; easier to heal a small and new gastric ulcer than an old and deep one. These are fine sentiments, but will the doctor really give an adequate office study to the patient who has no complaints—only a desire for a "thorough check-up"? It can be done. It needs patience, and interest, and professional competence, and above all, that special kind of imagination which sees the limitless possibilities of preventive medicine in the doctor's office.

PATIENTS' CLUBS

With so many other groups organizing and lobbying, it was perhaps inevitable that patients should fall in line. While patients' clubs are not exactly new, their growth has been exceptionally rapid during the last few years. We now know of hay fever organizations, diabetics' clubs, leagues of former mental hospital patients, and societies for spastics, not to mention incubator alumni and Alcoholics Anonymous. The M.D. has a stake in this movement, since after all the only thing which the members have in common is that they are (or ought to be) under a doctor's care. These clubs offer the profession an opportunity for sharply focussed public health education, a potent ally in efforts to enact better health legislation, and sometimes a fresh and useful therapeutic tool. Even psychiatry, last bastion of individualized medicine, has accepted group therapy. For any specialty, a patients' meeting offers a first rate opportunity for giving therapeutic advice en masse. Every such club needs a medical adviser, and the wide-awake physician will welcome invitations from an honest organization of patients.

ORIGINAL ARTICLES

THE PROBLEM OF THE LONG-TERM PATIENT IN NEW JERSEY

EMIL FRANKEL
Department of Institutions and Agencies, Trenton, N. J.

In the "chronic" disease group there are included generally those affections which persist for relatively prolonged periods of time, as contrasted with "acute" illnesses of short duration, or convalescence periods of only a few weeks.

Patients suffering from chronic diseases generally are unable to follow the customary daily routine of the average person and are in need of medical or nursing care of varying extent and over prolonged periods.

Earnest efforts are being made in New Jersey to see the problem in all of its phases and to develop a rounded program which will meet the serious personal, social and economic consequences of chronic illness.

As expressed by one of the outstanding students of the problem of chronic disease "with the increasing awareness and study of the medical needs of all the people, with public and private agencies and the organized profession of medicine devoting their major attention to questions of medical care and disease prevention, chronic disease must be recognized as an insistent and substantial element in the whole picture."*

As the average expectancy of life increases, so does the proportion of persons of the ages in which we find the majority of the chronically ill. It has been observed that "with the progressive decrease in death rate from infectious diseases in recent years, more and more persons survive middle life to succumb at a more advanced age to disease obscure in origin and chronic in character."

Table I illustrates the growing number and proportion of the "older folks" in New Jersey's general population over a sixty-year period.

The life expectancy at birth which was fifty years in 1900 reached sixty-five years in 1945.

During the last ten years there have taken place significant shiftings in the major age groupings of the general population in New Jersey as displayed in Table II.

TABLE I
Population 65 Years and Over

Year	Number	Per Cent in Total General Population
1880	45,242	4.0%
1900	79,617	4.2%
1920	133,481	4.2%
1940	278,821	6.7%

TABLE II

Age Group	General Population 1930	1940	Per Cent Change 1930 to 1940
All Ages	4,041,334	4,160,165	+ 2.9%
Under 15 years	1,094,928	874,762	—20.1%
15-44 years	2,009,033	2,092,771	+ 4.2%
45-64 years	733,626	913,811	+24.6%
65 years and over	201,043	278,821	+38.7%

According to the 1936 National Health Survey the following New Jersey figures may be deduced:

177.0 Persons per thousand population reported to have chronic disease or impairment, would give 736,350 persons in New Jersey.

11.4 Invalids (permanently disabled) per thousand population would give 47,425 persons in New Jersey.

The estimated number of chronic disease cases and invalids in New Jersey among the more important chronic diseases are given in Table III.

TABLE III

Disease	Estimated No. of Chronic Disease cases in New Jersey	Estimated No. of Invalids in New Jersey
Rheumatic Diseases	226,050	4,870
Heart Diseases	122,100	4,750
Arteriosclerosis and High Blood Pressure	122,100	2,010
Nephritis and other Kidney Diseases	51,150	1,020
Cancer and other Tumors	30,690	920
Diseases of Female Organs	23,760	610
Diabetes Mellitus	21,780	1,130

* *The Unseen Plague: Chronic Disease*, by Ernst P. Boas, M.D. J. J. Augustin, New York, 1948.

The significant changes in the age distribution of deaths occurring in New Jersey in the forty-five year period, between 1900 and 1945, giving a striking illustration of the effects of the public health and related movements are illustrated in Table IV.

TABLE IV

Age at Death	Per Cent of Total Deaths in Specified Age Group	
	In 1900	In 1945
Under 5 Years	33%	6%
5-19 Years	7%	2%
20-59 Years	34%	32%
60 Years and Over	26%	60%
Total	100%	100%

The mortality from the major chronic diseases which occurred in the total of 47,633 deaths in 1945 is shown in Table V.

TABLE V

Cause of Death	Number of Deaths	Per Cent of Total Deaths
Heart Disease	16,825	35.3%
Cancer and other malignant tumors	7,077	14.9%
Nephritis and other Kidney Diseases	3,022	6.3%
Diabetes Mellitus	1,409	3.0%
Arteriosclerosis and High Blood Pressure	1,040	2.2%
Diseases of Gall Bladder and Liver	784	1.6%

"Chronic diseases create not only medical problems, they are a major cause of social insecurity; their malign influence permeates into all phases of our living, causing indigency and unemployment, disrupting families and jeopardizing the welfare of children."†

Among 21,000 recipients of old age assistance nearly 40 per cent were classified as "chronics" in a recent study made by the New Jersey State Department of Institutions and Agencies.

In summarizing the present methods employed in caring for the chronically ill among old age assistance recipients it is remarked that they "range from adequate to totally inadequate".

Licensed Nursing Homes are utilized to the fullest extent possible and 500 to 600 recipients of old age assistance are maintained in such homes.

Boarding Homes are also used and since they are not licensed the adequacy of care varies greatly.

Visiting Nurse services are utilized to the fullest extent.

Another group of cases are cared for by practical nurses in their own homes where no other arrangements can be made.

A large group is taken care of in their own homes by members of their families and of course again the adequacy of care has a wide variation.

Some County Welfare Boards are utilizing the facilities of county institutions for chronic patients, but such institutions are insufficient. And there are not enough beds in those that exist. Moreover, the counties are reluctant to use these beds for persons otherwise eligible for Old Age Assistance because they get no state or federal aid for such care. They prefer to reserve their facilities for persons not eligible for the state and federal funds.

As seen by the State Department of Institutions and Agencies "the most practical program for meeting existing needs would be to establish state aid for operating costs of county institutions, or county and municipal institutions meeting minimum standards of care, plus state aid for the chronic sick who are under 65 years of age and can be cared for in the community along the lines provided for Old Age Assistance. Extension of existing Visiting Nurse Association services to include visiting housekeepers would also be a desirable step which we believe should be spearheaded by the private agencies, but for which public funds for services rendered to old age assistance recipients should be made available."

In a recent period nearly 3,000 chronically ill persons were receiving general municipal public assistance according to the findings of a state-wide survey conducted by the New Jersey State Department of Economic Development.

Among some 5,000 cases more than 3,100 were classified as "long term dependency cases" 91 per cent of these representing cases of chronic illness.

The Department of Economic Development has outlined the following program to meet the existing needs of the long-term patient: "The Municipal Aid Administration adopted a practical program in the latter part of 1943 designed to encourage the use of public welfare home facilities for the chronically ill. That program was fostered to develop the operation of public institutions on a sound, social and medical level. The state policy was predicated on certain fundamental principles; first, that

† By Ernst P. Boas, M.D. *ibid.*

the institutions would provide sufficient and proper nursing or medical service together with much needed modern equipment; and second, that they would strive toward a fuller bed capacity for the non-ambulatory cases."

CONSIDERATIONS IN A PROGRAM FOR THE CARE OF THE LONG-TERM PATIENT

The *general hospital* occupies an important place in the total program for the care of the long-term patient. The type and quality of care required by the patients suffering from chronic illness are practically the same as those required by the patient acutely ill. It may differ only in the amount of special services needed and the longer hospital stay required.

"From the standpoint of hospital and outpatient organization, the long-term patient is entitled to the same facilities as the short-term patient. No institution has ever been created which is better qualified to deal with the problems of long-term medicine than is the modern hospital. The general hospital where clinical and social vision is comprehensive and not limited to any specialty, where the patient is seen as a complete and indivisible problem, where age yields to scientific interest and scientific interest to age—there is the logical place for the long-term patient who requires these facilities." [1]

With greater frequency the *nursing home* is being called upon to care for the chronic patient and the patient who needs long-time care for an illness from which there is little hope of recovery but which does not require the type of service afforded in general hospitals to patients with acute illnesses.

A nursing home is defined by New Jersey law as a "home for care, treatment, and nursing of persons who are ill with disease or who are crippled, infirm, or in any way afflicted". Such a home becomes subject to license if two or more persons are cared for at one time and the power of license and supervision is vested in the Department of Institutions and Agencies.

The county *welfare house,* equipped for infirmary care of the sick is an indispensable link in the chain of institutions caring for the indigent chronically ill. These welfare houses (as well as the almshouses) are among the oldest of our county institutions, and are subject to supervision by the Department of Institutions and Agencies. The welfare houses realize that the majority of persons admitted for care are essentially the chronically ill in need of active medical treatment.

A peculiar responsibility rests upon the county officials in charge of public welfare houses to recognize the present-day needs of the long-term patient and make such changes in facilities, equipment, personnel, and management as may be necessary to meet their special requirements under the guidance of the State Department of Institutions and Agencies.

The *hospital for chronic diseases* is a distinct institution that combines for the chronically ill the services of a general hospital and a nursing home on a large scale. It is one step in advance of a welfare house. The latter has developed along lines made necessary by the patients already under care, while the hospital for chronic diseases has been designed from the beginning to give to the chronically ill every service for their comfort, happiness, and restoration to health insofar as possible.

There should be a hospital section for diagnosis and treatment and a custodial section for domiciliary care. Special provision should be made for (a) those needing active medical care for diagnosis and treatment (b) those needing chiefly skilled nursing care and (c) those needing custodial care only.

As it is possible that the less populous counties may lack the financial resources to establish such hospitals it is recommended that district hospitals for chronic disease be considered which would take care of long-term patients from several counties.

Home care may precede or follow hospital care, or itself be adequate for any types of chronic disease patients if home conditions are favorable, and home activities can be so regulated that the presence of the patient will not disturb the family life.

The services of nurses available through the Visiting Nurse Associations and kindred organizations can be utilized most advantage-

1. Bluestone, E. M.: *Bulletin,* American College of Surgeons, June, 1946.

ously in the nursing care of long-term patients.

In order to make home care of long-term patients more feasible and to reinforce the work of the visiting nurse, a corps of *housekeeping aides* should be available. These aides can assist in the housework of the chronically ill who are not strong enough to do their own unaided. This adds greatly to the comfort and happiness of semi-invalids living by themselves and also helps those who keep the home who might otherwise be overwhelmed.

HOSPITAL FACILITIES NEEDED FOR LONG-TERM PATIENTS

Considering the two county hospitals for chronic diseases (Camden and Hudson), and including public welfare houses and the small proprietary nursing homes, we have provisions for about 5,000 long-term patients, as indicated in Table VI.

TABLE VI

Institution Auspices	Number of Institutions	Number of Beds
County Hospitals	2	390
Welfare Houses offering chronics care	17	2,968
County	(14)	(1,899)
Municipal	(3)	(1,069)
Nursing Homes—Proprietary	85	1,621
Total	104	4,979

The Federal Hospital Survey and Construction Act sets a limit of 2 beds for chronic disease patients per 1,000 general population under which federal funds may be granted for sharing with local funds.

On that minimum basis New Jersey would utilize a total of 8,320 beds for long-term patients.

In regard to the establishment of hospital facilities for the long-term patient the United States Public Health Service makes the following comment:

"It is believed that constructing chronic disease hospitals as administrative parts of general hospitals will go further to insure active treatment of chronic disease patients and more hope of improvement for remediable cases than constructing them as independent hospitals."

"When this is found impractical, independent chronic disease hospitals should be located as near as possible to general hospitals. With respect to either type, it must furnish medical and hospital care under the supervision of a member of the medical profession."

CENTRAL INFORMATION SERVICE

It is desirable that a Central Information Service be established in the community, which might well function under the auspices of the Visiting Nurse Association or a related organization.

Such a Service would promote sound community action by offering leadership in coordinating the work of the agencies directly concerned in the care of the long-term patient and in acquainting the public with its responsibilities and obligation in regard to the long-term patient.

In line with the general pattern set for a Central Information Service for long-term patients the following might be outlined as its functions:

1. To maintain up-to-date information on facilities available for the care of the long-term patient and to provide information about these facilities to patients and their families, physicians, social and health agencies and others.

2. To provide counseling and other medical social services, where planning is necessary for care of a chronic illness and where such services are not available through another agency.

3. To accumulate and analyze information regarding the specific nature, extent, and causes of inadequacies in existing facilities in the community; to clarify issues and formulate specific proposals for additions and improvements in the community service.

4. To formulate specific standards of care and of reasonable cost of the various services and supplies necessary for the adequate care of the chronically ill.

PREVENTION OF CHRONIC DISEASE

In a stimulating paper by Dr. David Seegal and associates ("Progress in Control of Chronic Illness") chronic diseases are arrayed in three groups: (1) Largely controlled (2) Partly controlled; and (3) Uncontrolled. Specific measures for the further control of chronic illnesses are outlined and the paper concludes with an encouraging note:

"The brilliant results obtained in the treatment of acute infectious diseases with modern chemotherapeutic agents have overshadowed the less dramatic progress which has been made in the

control of chronic disease. However, when the latter is examined it is apparent that medicine has made considerable headway in this difficult field. Many chronic diseases which produced disabling illness 30 years ago are now controlled. Major developments in surgery have also favorably influenced the natural course of a number of chronic illnesses."

In the report of the National Health Survey appear the significant remarks that "there is an ever growing concern in the United States over the problems presented by chronic disease. If the statement is accepted as valid—that the greatest need for action in the field of public health is where the greatest saving of life and prevention of suffering can be made—then, without doubt, the chronic diseases merit the attention they are receiving."

Tables VII and VIII provide the basic source data on which plans for meeting this problem must be based.

In order to receive grants under the Federal Hospital Survey and Construction Act, "the total number of beds required to provide adequate hospital services for chronic disease patients shall not exceed *two per thousand population*".

TABLE VII
CHRONICALLY ILL IN NEW JERSEY [2]

County	General Population (1940 Census)	Number of Chronic Invalids	Number of Persons with Chronic Disease or Permanent Impairment
All Counties	4,160,165	47,425	736,350
Atlantic	124,066	1,414	21,960
Bergen	409,646	4,670	72,507
Burlington	97,013	1,106	17,171
Camden	255,727	2,915	45,264
Cape May	28,919	330	5,119
Cumberland	73,184	834	12,954
Essex	837,340	9,546	148,209
Gloucester	72,219	823	12,783
Hudson	652,040	7,433	115,411
Hunterdon	36,766	419	6,508
Mercer	197,318	2,249	34,925
Middlesex	217,077	2,475	38,423
Monmouth	161,238	1,838	28,539
Morris	125,732	1,433	22,255
Ocean	37,706	430	6,674
Passaic	309,353	3,527	54,755
Salem	42,274	482	7,482
Somerset	74,390	848	13,167
Sussex	29,632	338	5,245
Union	328,344	3,743	58,117
Warren	50,181	572	8,882

TABLE VIII
HOSPITAL FACILITIES NEEDED

County	Two Beds Per 1,000 of County Population
STATE	8,320
Essex	1,675
Hudson	1,304
Bergen	819
Union	657
Passaic	619
Camden	511
Middlesex	434
Mercer	395
Monmouth	322
Morris	251
Atlantic	248
Burlington	194
Somerset	149
Cumberland	146
Gloucester	144
Warren	100
Salem	85
Ocean	75
Hunterdon	74
Sussex	59
Cape May	58

2. (Estimated number based upon ratios established in National Health Survey in 1935-36.)

PREVENTION OF THE COMMON COLD

ARLINGTON BENSEL, M.D., East Orange, N. J.

To the American economist, the common cold is the cause of incalculable financial loss. It has been stated [1] that the average American has one to four colds a year; and that the time lost at work must be worth a billion dollars annually. Aside from these losses, the common cold causes untold discomfort and often sets the stage for many other diseases — otitis, pneumonia, septicemia, bacterial endocarditis, meningitis and others. While there is no "cure" for a common cold, it is likely that knowledge of the cause will lead to prevention on a large scale.

The common cold is usually defined as a catarrhal inflammation ("irritation" would be better terminology, as I shall point out later) of the upper respiratory passages. The causal agent may be a filtrable virus. It is my opinion that entirely too much emphasis has been placed on the following:

1. The infectiousness or communicability of upper respiratory infections. 2. The virus hypothesis. 3. Chilling or wet shoes with resultant vasoconstriction of the vessels of the nasopharyngeal mucosa and ischemia. 4. Fatigue or diminished resistance. 5. Emotional strain. 6. Irritants in the air. 7. Coughing or spread by droplet infection.

Let us re-evaluate some of the physical phenomena that occur on the lining mucosa of the respiratory apparatus. Of primary importance is the exchange of gases in the alveoli or terminal bronchi. The process is well covered in any good text of physiology. Of secondary inportance are the functions of the upper respiratory passages in preparing the inspired air so that conditions will be ideal for the exchange of oxygen and carbon dioxide in the alveoli. For all practical purposes a sample of alveolar air may be considered to be at body temperature [2] and saturated with water vapor. It is assumed that the tidal air picks up heat and water vapor from the nasopharyngeal mucosa as it proceeds downward and becomes mixed with the supplemental air in the lungs. There are, therefore, two processes which take place in the upper respiratory passages both of which account for loss of heat (or energy) from the mucous membranes. These are: evaporation of moisture and transfer of heat to the inspired air.

Under average conditions and at rest, the amount of water evaporated in the respiratory passages during twenty-four hours is about 600 cubic centimeters. This will vary considerably depending on individual differences, such as, variations in tidal air or respiratory rate. The figure is also dependent on the relative humidity or water vapor content of the inspired air. If the inspired air is saturated with water vapor and at body temperature, there will be absolutely no evaporation or heat loss into the inspired air. This actually prevails in some tropical areas where acute coryza is vitually unknown.

However, it is our custom to live in artificially heated buildings and inhale warm, dry air which causes a tremendous amount of evaporation from a relatively small area of the mucosa of the nasopharynx. This evaporation is an irritating process. It is also a cooling process; in fact, it is a refrigerating process that requires much caloric energy in the form of heat to counteract. If the relative humidity of the inspired air is low, the mucosa becomes dry in an effort to supply the inspired air with much needed water vapor. The dry mucosa becomes shrunken and fissured. A portal of entry for the virus or the pathogenic bacteria is now open. This secondary stage is characterized by edema and mucopurulent discharge. Then the process may spread by way of lymphatics or by continuity through the submucosa, and later ulceration and actual necrosis of mucous membrane may occur.

The relative humidity in the average, heated, American home during the cool and cold months of the year varies from 10 to 50 per

1. Fabricant, N. D., American Journal of the Medical Sciences, 214:458 (April, 1947).

2. Christie and Loomis assert that the alveolar air is not fully saturated and that the temperature of the lung is lower than assumed.

cent. With an outdoor temperature of zero centigrade and an indoor temperature of 18 centigrade, the relative humidity is about 25 per cent. A relative humidity of this low ratio predisposes to upper respiratory infections.

To maintain a relative humidity above 50 per cent, it is necessary to vaporize mechanically approximately one gallon of water per day for each 3000 cubic feet of space, or about seven gallons per day for a ten room house. These figures will vary, depending on inside and outside temperatures, outside relative humidity, convection currents inside the building, cold surfaces for condensation, etc. However, simple, accurate hygrometers are available for measuring relative humidity.

If the water vapor in the atmosphere of our homes, hospitals, schools and office buildings can be maintained above 50 per cent relative humidity, it is the writer's contention that the incidence of common colds will be negligible.

SUMMARY

1. The economic importance of preventing common colds is great.

2. The physical phenomena concerned with heat lost through evaporation of moisture from the nasopharyngeal mucosa and direct transfer of heat to the inspired air are reviewed.

3. More emphasis is placed on the role of relative humidity in inspired air as the important etiologic factor in the common cold.

4. It is suggested that prevention of the common cold may be attained by maintaining relative humidity at a high level in homes, hospitals, schools and office buildings.

85 South Harrison Street

METHADON—A NEW ANODYNE

A new drug, made available in 1948 has been found effective in the alleviation of many kinds of pain, according to E. B. Troxol in the April 3 issue of the J.A.M.A. The drug, which was given the non-proprietary name of *methadon* by the Council on Pharmacy and Chemistry of the American Medical Association, was originally prepared by German chemists and was known as drug 10820. Clinical trials of methadon were instituted at the University of Minnesota Hospitals and it was tried on 400 patients for relief of all types of pain.

Some of the conditions for which it was used to alleviate pain were: postsurgical, primary and metastatic cancer, arthritis, neuritis, headache, leg ulcer, anginal pain, and gastric and duodenal ulcers.

The drug was administered orally—in capsules, tablets, and elixir—and by hypodermic and intravenous injection.

Onset of action was two minutes when given intravenously, within 20 minutes when given hypodermically, or when given orally as the elixir, and 30 minutes when given orally in capsules or tablets.

By all routes the average duration of action was four hours, with many patients obtaining relief for as long as 12 hours.

The new drug had some of the characteristics of both morphine and merperidine. Effects on the nervous, circulatory and respiratory systems were similar to those of morphine. It was found that methadon was more potent than either morphine or merperidine.

One group observed the effects of methadon in former morphine addicts and found that the abstinence symptoms from morphine could be controlled with methadon. When methadon was withdrawn abruptly after prolonged administration, the symptoms were so mild that treatment was not necessary.

It was found that 81 per cent had adequate or complete relief of pain, and that this figure would be increased to 86 per cent if the group of patients who received methadon for labor pains were excluded, since the drug has proved ineffective in this type of pain.

Approximately 20 patients receiving methadon for two or three months had no withdrawal symptoms on abrupt discontinuation of treatment. Three patients were given the drug for one year and were able to stop treatment abruptly without ill effects.

CONSTRUCTIVE AND DESTRUCTIVE ASPECTS OF ATOMIC ENERGY*

JOHN H. LAWRENCE, M.D., Berkeley, California

All of us are familiar with the lethal effects of large doses of x-rays or gamma rays on the human body. The radiologist must always be on guard when using x-rays in therapy. Body cells can be classed with reference to their relative sensitivity to irradiation. Most sensitive are the bone marrow, the endothelium of the intestines, and the lymphoid tissues. Whether we are studying the effects of x-rays, gamma rays from radium or from some artificially induced radio-element, or applying neutron rays directly from a pile or a cyclotron, all of these penetrating radiations affect tissues (when given in large doses) in a similar fashion. Histologically, it is not possible to differentiate one penetrating radiation from another when large single doses are involved.

In 1935, while working out health safety measures for the staff of the Radiation Laboratory in Berkeley, we studied the comparative effects of neutron rays, gamma rays and x-rays on normal mice and rats. At that time many young men were working around the 60" cyclotron, and they were exposed to continuous small doses of a mixture of two radiations, gamma rays and neutron rays. The latter rays (which are particulate and not really rays at all) had never been studied before from the biologic or medical viewpoint. We found these rays penetrated and destroyed tissue in doses from 1/5 to 1/10 those necessary when using x-rays or gamma rays. Since that time, men working around cyclotrons or atomic piles have been protected from exposures greater than 1/10 the so-called "safe" daily dose for x-rays or gamma rays.

Not well understood is the mechanism by which irradiation affects cells, whether after a massive dose or after prolonged exposure to small doses. It is believed to be related to ionization caused by the radiations entering the tissues. Possibly the recombination of these ions in the tissues leads to the formation of toxic products; or the ionization itself may destroy vital areas of the cell.

Ionization may be accomplished in a Wilson cloud chamber which can be bombarded with a mixture of neutron rays and gamma rays. The cloud chamber is filled with an argon-alcohol-water vapor mixture; and when these gases are suddenly expanded by means of a piston, there is supersaturation and the water vapor condenses along the paths of the ions. Fine thin paths indicate the tracks of ions formed by the beta particles which are emitted when the gamma rays strike, while thicker tracks are traced by neutron-proton ionization —100 times denser. Per centimeter of path there are roughly 100 times as many ion pairs along the proton tracks as along the electron tracks. This "density of ionization" is a factor in biologic effect per ion pair. Per centimeter of path in tissue, much more energy is lost in the case of the denser ionization. The biologic effect goes up with density, even though the total ionization is the same.

Neutron rays penetrate deeply into tissues and then cause protons to be emitted which cause a relatively dense ionization.

We have studied the small intestine, spleen and bone marrow 4½ days after irradiation with 272 n of neutrons, or 1000 r of x-rays. Both of the latter whole body doses are lethal to the animals in from five to ten days. The complete loss of the endothelium of the intestine, the destruction of the lymphoid tissue of the spleen and the nearly complete aplasia of the bone marrow in the case of the neutron-irradiated or x-irradiated animals is easily shown. All of us are familiar with this general picture of the effects of irradiation on the body—with death resulting from toxicity, bleeding into the tissues, anemia and infection following the marrow aplasia. As predicted the effects of the irradiation on animals at Bikini were similar.

* The Harrison S. Martland Lecture of the Essex County Anatomical and Pathological Society. Read by invitation, Newark, N. J., April 14, 1947. Abstracted from the lecture.

The lecture was illustrated with numerous lantern slides, some of which are referred to in the text.

In 1935 we reported on rats given massive doses of neutron rays with some gamma rays mixed in. Usually there was marked leukopenia and a terminal infection around the eyes. Interestingly enough, these experiments carried out in the summer of 1935 (in which rats were given single large doses of neutrons and gamma rays) predicted the effects to be expected from the irradiation from the atomic bomb when it came along a decade later. When it is exploded, it emits a sudden burst of irradiation—a mixture of neutrons and gamma rays also and animals and humans studied later gave this same general picture.

Last summer at Bikini I had an opportunity to see what a single one of these bombs can do not only to ships, but also to the animals and humans on them. In addition to the blast effects, which cause damage in such a wide area, there are the tremendous effects of heat and radiation; and the latter may cause the deaths of animals or humans even though they are several thousand yards from the center of the explosion. Sufficient doses of irradiation lead to death from anemia, hemorrhage, and infection after weeks or months in some delayed cases. In addition to the irradiation which is generated instantaneously at the time of the explosion, there are the tremendous amounts of artificially induced radio-elements —some with very long half-lives—which are widely scattered in the area, making such an area uninhabitable for months or years. An area such as Newark could thus be made uninhabitable for a long time if two or three of these bombs were released on this city.

What of the effects of chronic exposure to low doses of irradiation over long periods of time? We all know of Harrison S. Martland's research here when he showed the real dangers of such chronic exposure. Briefly, his work with radium dial painters showed that radium taken orally becomes fixed in the skeleton, and (as a result of chronic bombardment of the tissues of the bone and marrow), serious complications occur, such as radiation anemia, osteitis, radio necrosis and frequently osteogenic sarcomata. Five to fifteen years after tipping their brushes on their tongues with the dial paint, extremely small amounts in the skeleton (from 10 to 200 micrograms) were sufficient to cause these changes.

We now have another new industrial health hazard brought about by the atomic energy program. In the manufacture of the atomic bomb, and in the manufacture of various artificial radio-elements in the pile, the workers are potentially exposed to a large group of radioactive elements, which like radium localize in bone after ingestion or injection. These materials are either the original elements themselves (such as plutonium, uranium, thorium and radium) or the several fission products, such a radioactive forms of strontium, yttrium, cerium, columbium, and many others, all in the middle of the periodic table from element 88 to 96. In the atomic energy industry, chief dangers from these materials are inhalation of dust containing them, or their entry into the body orally or through a cut on the skin. These materials, like radium, become fixed in bone; and since many of them have long half-lives, the result is chronic long-continued irradiation of the marrow and of the bone structure itself. Dr. Hamilton, Miss Axelrod and their associates have made a study of the distribution of these materials. Rats were given these various radio-elements — intraperitoneally—and later they were sacrificed and 10 micron thick sections of bone were made. Autoradiographs were accomplished by placing these sections against x-ray film. These were then compared with the same section stained and examined histologically.

In general the elements in this group tend to become deposited in the osteoid matrix, i.e., in the endosteum or in the periosteum. An exception is radioactive strontium, which is deposited in the bone structure itself and in this respect it acts like radium.

It has been found by Brues and his associates that when these elements are administered chronically to animals such as rats, mice and rabbits, in sufficient dosage (or in small doses repeated frequently) tumor induction may follow after many weeks or months even though the animal does not die immediately from the direct effects of the

radiation. For example, strontium ^{89} (half-life 53 days) when given in a single dose as large as 2.5 microcuries per gram or a total dose of 75 microcuries per *mouse* will result a year later in half of the animals developing osteogenic sarcomata, and if given in repeated doses of 0.2 microcuries per gram or 6 microcuries per mouse every month, about a third of the mice eventually will develop osteogenic sarcomata. Indications are, with some of the other elements, that if present in sufficient quantity, osteogenic sarcomata will result. This includes uranium and plutonium. Plutonium and uranium are also toxic chemically in addition to their radiation toxicity.

MEDICAL APPLICATIONS

So far I have discussed some of the destructive aspects of atomic energy and the dangers involved in its use. In medical investigation, we must keep these hazards in mind. From the cyclotron and now from the atomic pile, there are available radioactive forms of nearly all the chemical elements — from hydrogen on up the series to element 96, recently discovered. They have possible value as sources of therapeutic irradiation and as tracers in metabolic studies. The latter application is by far the most important.

The nuclei of all atoms are made up of two fundamental particles—the neutron and the proton. The number of the latter determines the chemical nature of an element, since it determines the total charge on the nucleus. Hydrogen has one proton, heavy hydrogen—(an isotope of ordinary hydrogen) —one proton and one neutron, helium two protons and two neutrons, etc., on up the scale. If we continue we arrive at uranium with 92 protons and enough neutrons to make up for the atomic weight of uranium.

Isotopes of the elements are chemical forms with different numbers of neutrons. For example, in iron sulfate (used therapeutically in the anemias) there is a mixture of five different isotopes of iron, having different atomic weights and therefore different numbers of neutrons, but all having the same charge on the nucleus, i.e., the same number of protons in the nucleus of their respective atoms. These isotopes of iron are stable, in contrast to radioactive isotopes which are unstable. They are unstable because they have an imbalance between atomic charge and atomic weight and in attempting to get back into balance, these isotopes emit energy in the form of rays. Most of those produced artificially have half-lives, which are short compared to that of radium, which loses half its activity after 1500 or more years. Many of these artificial ones have half-lives of only a few days.

Atoms are really small. In one gram of flesh such as muscle, there are roughly 10^{22} atoms or 10 with 21 ciphers after it. A man of average height is 200,000 times as tall as the diameter of the red cell; the diameter of the red cell is 200,000 times the diameter of the carbon atom, and the diameter of the carbon atom is 200,000 times the diameter of the nucleus of the carbon atom.

In the artificial production of these radioactive isotopes the physicists and engineers make fast moving atomic bullets and direct them against targets of various elements and by introducing or taking out protons or neutrons, change the balance of the nucleus and make them radioactive. The cyclotron and the atomic pile produce such "bullets". Another method of producing these isotopes is by the fission process in the pile. Uranium or plutonium after neutron capture splits into two fragments, and these fragments may be radioactive.

To measure radioactivity, we have the Geiger Counter which tallies the number of radiations emitted by a sample per minute. These counters are built as ruggedly as radios.

For therapeutic irradiation, we look for elements or compounds which can be caused to localize in the part of the body needing irradiation. Up to the present, a few such applications have been found. They are: first, skin cancer is being successfully treated with *sodium radio-phosphate* by placing over the neoplasm a piece of blotting paper cut to the size of the neoplasm and saturated with the solution, and leaving it there for the calculated time. Phosphorus ^{32} emits beta rays only and these penetrate only a few milli-

meters into tissue. Thus the deeper tissues are not treated or damaged. The radiation is given chiefly to the superficial skin cancer. Second, *radioiodine* in the form of sodium or potassium iodides given orally localizes to a high degree in the thyroid gland and thus it is possible to treat with selective irradiation hyperplastic thyroid disease or Graves disease and also certain cases of thyroid cancer. Third, *radio-phosphorus* in the form of a compound such as sodium phosphate localizes in bone marrow, leukemic tissue and bone itself. It is thus possible to give some degree of selective irradiation in diseases such as chronic leukemia and polycythemia vera with considerable success. Fourth, certain radioactive colloids, which localize in the spleen, liver and bone marrow are now in use in the treatment of diseases involving these tissues.

In the case of phosphorus given therapeutically we are dealing with serious diseases and using relatively small doses—if one can extrapolate from the white mouse or rat—weight for weight. Our doses are something like 1/25 of those producing tumors in the animals. To date we have no evidence (in our experience with over 500 patients since 1936) of tumor induction and we have under observation over 100 patients who are living after five or more years of therapy.

With the tracer technic we get a dynamic picture of metabolism using "safe" tracer doses, i.e. doses which are calculated not to produce immediate or delayed harmful effect on the body but dosage large enough so that the radioelement or compound can be detected. All of us receive constantly a small amount of irradiation from cosmic rays and from natural radio-activity in the earth. A safe tracer dose gives the body only slightly more irradiation than all of us are constantly receiving and for a relatively short period of time. This can be illustrated by the following experiment on a rabbit. This rabbit was given a gamma-ray-emitting colloid which remains in the blood stream with little loss to the tissues or to the urine or feces for long periods of time. Thus if counters are placed over various organs of the body, we can determine the speed of complete mixing of the blood in the whole body and various parts of the body. Counts per minute are plotted against time after intravenous injection. Three counters are used—one over the liver, one over the heart and one facing the lower extremities. Considerable time is necessary for equilibrium and complete mixing to take place. The blood circulates rapidly and in large volume through the heart and liver but very slowly and in small volume through the extremities and all curves become level only after a relatively long period of time. Experiments of this type have been carried out on humans also and it is surprising to find that complete mixing of the blood or of a dye or colloid may take as long as twenty minutes. The extent of our understanding of the circulation is being increased by this technic.

In the laboratory and clinic we have now worked with over sixty different radioactive elements in tracer metabolic studies. Perhaps the more valuable and interesting isotopes are those of iodine, phosphorus, iron, carbon, and hydrogen. If we had these and no others, many investigators would have a busy and interesting time for many years to come.

In closing I should like to describe some experiments now under way in the laboratory with two organic compounds which are of physiologic and medical interest. Consider the structure of the compounds *tyrosine* and the cancerogenic hydrocarbon *dibenzanthracene*. Our chemist colleagues, Reid and Heidelberger, have synthesized these compounds starting with radio carbon, i.e., the isotope which has a half-life of over 6000 years. This means that after injection or ingestion by the animal body, we can get a dynamic picture of what happens to a single dose of these materials. There is no accurate previous information to answer these questions. (In the lecture the findings in mice were described and discussed.)

At the present time and in the near future I think that radioactive materials will be largely research tools, and of diagnostic value in some instances. As of today, they haven't entered the therapeutic field to any important degree. I do think, however, there should

be numerous centers where they are being investigated. Every patient with thyroid cancer, prior to operation, should have a "tracer" test with radio iodine, to see if there is selective pick up. This information would be of value later if radiation therapy is considered. In the research laboratory and in the investigative clinic, radio elements with the Geiger Counter will be as necessary as the microscope is now; but their dangerous potentialities must always be kept in mind when they are being used by the physician.

Division of Medical Physics
University of California

MEDICAL OPPORTUNITIES IN ARMY

The attention of all readers is invited to the opportunities for physicians in both the Regular Army and in the activated Reserve. In that connection the following letter from the Commanding General of the First Army is published:

Dear Dr. Schaaf:

In connection with the current urgent shortage of physicians, dentists, and nurses in the military service, I feel it desirable to request the advice and assistance of the many doctors who are members of Army Advisory Committees.

Complete staffing of medical installations in my command at this time would require 207 Medical Corps officers in the various grades and specialties to carry the heavy work load; we are now below that strength. Furthermore, we expect to lose by separation before 30 June 1948 approximately 95 officers, with no prospect of substantial replacement. The situation with respect to dentists and nurses is similar.

You will appreciate the strain on morale incident to the overwork, extra duty hours, and disruption of hospital and dispensary procedures, all traceable to the shortage in trained medical personnel.

The First Army Surgeon is bringing this problem to the attention of the various medical societies and organizations in this Area. You will undoubtedly be asked to cooperate in the general effort.

Beyond that general effort, I would greatly appreciate your advice on a personal basis. I think you will agree that in the last analysis the solution of the problem must rest on obtaining those individuals in the medical professions who for one reason or another are at this time interested in either a temporary or permanent tour of duty with the Army. There may well be, within your professional acquaintance, some physicians, dentists, and nurses whom you could recommend with confidence in their ability, and who might desire service in the Medical Corps of the Army.

I ask you to consider this problem as within your special field of interest. I shall later bring the situation to the attention of the Army Advisory Committee as a whole. I wanted, however, to have the benefit of your early counsel.

I ask it on the ground that the standards of the Medical Corps can be maintained only by obtaining highly qualified personnel in adequate numbers. I ask it in the conviction that the overall efficiency of the Armed Services is a matter which must fundamentally concern every loyal citizen in these troubled times.

Sincerely yours,

COURTNEY H. HODGES,
General, U. S. Army.

INDUSTRIAL SIGHT CONSERVATION PROGRAM FOR NEW JERSEY

Herbert Weltchek, M.D., Elizabeth, N. J.

The need and the desire for industrial sight conservation has long existed. Indeed various features of an industrial sight conservation program have been developed from time to time in the past, but no complete and coordinated plan has been put into effect until recently. The New Jersey State Department of Health, through its Division of Adult and Industrial Health, has such a program presently in operation. Main factors in industrial sight conservation are:

1. Vision, or the eyes and their functioning.
2. Illumination; under which comes good lighting and color of working areas.
3. Eye safety.
4. Education.

Each taken alone and developed will result in definite value to worker and to management; all developed as an integrated program will result in far greater benefit than the sum of the individual items. Adequate examination of the eyes and of vision in industry can be accomplished in a very short time per employee. Care must be taken to consider in this examination that problems of seeing in industrial work are often unique to that work and find no counterpart elsewhere in our daily lives. Proper examination of vision for industrial purposes should include (a) vision at 20 feet (b) vision at approximately 14 inches (c) vision at working distance.

VISION AT WORKING DISTANCE

The vision at working distance is by far the most important part of the examination. In many instances, vision "at distance" and the vision "at near" do not correspond to vision at working distance. In an industrial procedure where fine, or even gross, work is done at a distance of 20 inches from the eye, it is useless to test vision for ordinary "near" and to attempt to correct it by the usual correction for near vision, i.e., 14 inches. This example can be carried on *ad infinitum*. All too often this feature is overlooked in testing vision in industry and in prescribing corrective glasses. It is equally important to remember that in glasses correcting vision for 20 inches, the optical centers of the lenses of those glasses are different than the optical center of lenses correcting for 14 inches. Improper centration of lenses can cause distortion and poor vision even when the refractive prescription is correct for the distance at which work is being done.

OPHTHALMOLOGIC EXAMINATION

Included are examination of extraocular muscles, color perception, ophthalmoscopic examination and general examination of the eyes. This is done at the plant. With this information assembled, arrangements can be made for those needing it to obtain proper refraction and/or other therapy. The physician and representatives of worker and management can confer on how to utilize best the visual capabilities of each worker.

ILLUMINATION

Good illumination, the second factor, depends upon proper and adequate lighting and proper color to enhance and develop the effects of the lighting. The goal is to reach a state of affairs like that occurring in nature; plenty of light for seeing with just enough (and not too much) of that light reflected from the object to be seen to the eye which is doing the seeing. It may be necessary in certain industrial procedures to furnish supplemental illumination. Color is used primarily as a reflector for light; consideration of the psychologic values of colors is also given in painting an area.

EYE SAFETY

Eye safety depends upon the foregoing factors, but also must be treated in additional ways: protective goggles or glasses, protection of eyes from glare and flash or harmful rays. Hand in hand with safety goes education. This cannot be a static affair. There must be a continual and varied means of telling people in industry *why* they should and *how* they can conserve their vision. This is done by posters, lectures, moving pictures, employee participation committees and demonstrations.

At its present stage the industrial sight conservation program for New Jersey is in the developmental and fact-finding phase.

PROGRAM DEVELOPMENT

About one year ago the program was begun with a conference of industrialists interested in such an endeavor. At this conference the program was explained and the cooperation of industry was solicited. The response was favorable, and the work started. Prior to this conference a great deal of work had been done to obtain the endorsement and assistance of groups and agencies which might in any way be concerned with this program. The support of all the New Jersey State Bureaus and Agencies has been freely given. Among those endorsing this effort are: The Medical Society of New Jersey, the Optometric Society of New Jersey, the New Jersey Department of Labor, the U. S. Public Health Service, the National Society for the Prevention of Blindness, the New Jersey Lions Clubs, the New Jersey Commission for the Blind, the CIO, the AFL, and other organizations. The industrial sight conservation program for New Jersey is a complete and permanent project which embodies the principles of good industrial sight conservation. It is offered to the industries of New Jersey as one of the many services of the Division of Adult and Industrial Health. Personnel operating the program are those of this Division: physicians, engineers, nurses, technicians, and clerks.

PILOT STUDIES

Five "pilot" studies in various industries throughout New Jersey are now in progress. A wealth of valuable factual material is thus being collected for the purpose of improving present concepts and practices of industrial sight conservation. These demonstration areas will serve as examples to other industries of the value of such effort. This is the first time that a fully coordinated program containing all the features of industrial sight conservation has been in operation. Sight conservation is not only humanitarian, but it "shows a profit". The worker who sees well, works well.

RESULTS

Advantages which have accrued from industrial sight conservation are: it conserves vision, reduces accidents, makes for better and easier production for the worker, reduces waste and cuts down on insurance and compensation costs. The industrial sight conservation program for New Jersey conserves, preserves and protects one of man's most precious —and entirely irreplaceable—possessions, his vision.

439 Jersey Avenue

COURSE IN NEUROPSYCHIATRY

Announcement is made of an intensive and practical course in neuropsychiatry to be given in Newark on Monday and Thursday evenings, beginning September 9, 1948, and running for fifteen weeks thereafter. The course is acceptable for the enrollment of physician-veterans under the "G.I. Bill of Rights". Tuition fee to nonveterans is $125. Rutgers University is administering the course, in cooperation with the New Jersey Neuropsychiatric Association. The sponsoring agencies describe the course as "fashioned to meet the needs of the physician who wants training in neurology and psychiatry, of the candidate for American Board examinations, and of the practitioner who desires simply to sharpen his skills in the specialty".

The course includes work in neuro-anatomy, neuro-pathology, psychopathology, neuro-roentgenology, psychodynamics, clinical neurology, clinical psychiatry, neuro-physiology, psychosomatics, electro-encephalography, psychotherapy, child psychiatry, group therapy, forensic psychiatry, mental hygiene, and related topics. Classes meet from 7 to 10 p. m. every Monday and Thursday evening throughout the fall, representing an aggregate of ninety hours of intensive work.

For program and application blank, write to: New Jersey Neuropsychiatric Association, 82 Clinton Avenue, Newark 5, N. J.

PROPHYLAXIS IN POSTOPERATIVE THROMBO-EMBOLUS*
(PRELIMINARY REPORT)

MORRIS JOSEPH, M.D., Passaic, New Jersey

During the past decade, the literature has been replete with articles on thrombophlebitis and embolus following operation. Since the introduction of heparin and dicumarol, this has been even more apparent.

Surgery has conquered many of its mechanical difficulties through improved technic. Also the boon of sulfa drugs, penicillin and other antibiotic agents has facilitated previously prohibitive surgical procedures and lessened the hazard of sepsis.

Surgeons, however, still seek a solution for the disturbing and dangerous embolus and thrombophlebitis that sometimes follows an otherwise perfect operation.

PREPARATION OF THE PATIENT

The most potent factor in postoperative thrombo-embolus is venous stasis. To reduce this danger, those items which have a strong tendency to precipitate thrombophlebitis should be given more attention. Thus, the anemic patient should be transfused to a normal level. The obese patient should be reduced to a reasonably safe weight if this is at all feasible. Cardiac patients should be compensated. Peripheral vein impairment should be corrected.

TREATMENT OF PHLEBITIS AND EMBOLISM

For simple phlebitis, bed rest, elevation of the limb and application of heat are usually sufficient. If there is high fever, sulfamerazine has, at least in my experience, been found useful. This drug is used because administration is necessary only twice in twenty-four hours. In the more severe types, femoral vein interruption should be accomplished promptly. A more extensive type of venous interruption may be necessary in some cases. I have never had occasion to use heparin or dicumarol in these cases. The few cases of embolism that I have had since the introduction of these agents have been fatal before active therapy could be instituted. Those who use heparin and dicumarol more extensively frankly admit that they have definite potential dangers. Fatal hemorrhages have occurred, and lesser hemorrhagic episodes are not at all uncommon. Although a careful prothrombin check once or twice daily is definitely indicated, many hospitals are ill-equipped to carry out such a procedure. Also the cost of this treatment in some cases would be prohibitive.

Preoperative administration of thyroid and other substances has been tried without much apparent benefit. Routine femoral ligations have not met with general favor. It is doubtful if patients would consent to such a procedure if they had full knowledge of its implications, except in such cases as described by Linton [1] where the probability of an embolism was great.

The actual occurrence of thrombophlebitis *per se,* without embolic complication is rarely recorded in the literature. Yet it is regarded as one of the most common postoperative complications. Patients often discharged from the hospital fail to report for follow-up observation. Among them, (especially with early ambulation and short hospital stay) mild cases are often overlooked. The patient may pay little heed to a slight swelling of one leg with moderate pain. I have had one such experience. This patient noticed some pain and swelling of one leg prior to her discharge, but she failed to report it because of "fear of being kept in the hospital". By the end of the third week the leg was markedly swollen.

Four-fifths of the cases of thrombophlebitis follow intra-abdominal procedures. Of these, 40 per cent are within the pelvis and 60 per cent upon the stomach, gallbladder, or appendix. In two-thirds of the cases the thrombophlebitis is in the left leg. The incidence is lower during the summer months and seems to follow roughly the curve of frequency of infections of the upper respiratory tract, though it is unsafe to place too great emphasis upon this analogy.

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* From the surgical department of the Passaic General Hospital. This paper was read before the Fall Clinical Conference of The Medical Society of New Jersey at Passaic, October 29, 1947.

1. Linton, R. R.: Journal of The Medical Society of New Jersey, 44:394 (October 1947).

Thrombophlebitis of the leg occurs in the distribution of the saphenous vein. According to Brown, about two-thirds of the cases are in the calf, about one-third in the thigh; in about 10 per cent, both areas are simultaneously involved.

INCIDENCE OF EMBOLISM

In the matter of embolism, the literature for the past twenty years is far more complete. The larger clinics in this country and England offer comparable data.

A study at the Ford Hospital included 118,611 operations. There were 280 pulmonary emboli of which 78 were fatal. In this group were 3,833 hysterectomies with 35 emboli, representing slightly less than one per cent. Of these, six were fatal, an incidence of 0.16 per cent.

In the Chelsea Hospital (England) fatal cases from embolus following hysterectomies were 0.4 per cent in 1936. They then reduced their fatality from postoperative emboli to 0.2 per cent by 1943. They attribute their improved record to active exercise and massage following operation.

The Philadelphia General Hospital reports a series of 1729 subtotal hysterectomies with four fatal emboli, a mortality of 0.25 per cent.

From the University of Minnesota there is a report of 25,771 necropsies from 1919 to 1939. In this series, there were 118 emboli following hysterectomies with 38 fatal or 0.25 per cent.

With more or less variation the ratio is similar from numerous other clinics. These reports do not include the use of anticoagulants.

Evans and Kassell in 1945 used anticoagulants in a series of 381 pelvic operations. There were no deaths, but there were 7 cases of thrombophlebitis and embolism.

The variance between some reports is considerable in the matter of both incidence and fatality from embolism. Danforth,[2] in 1941 reports no cases of embolism or phlebitis after vaginal hysterectomy in 425 patients. Likewise Vogt and Hamilton in 1942 report 500 hysterectomies with but one instance of embolism. In contrast a report by Barker[3] and others from the Mayo Clinic in 1940 listed 5730 hysterectomies. There were 87 cases of emboli (1.52 per cent) with a fatality of 42 (0.73 per cent).

From the Mayo Clinic also comes further interesting and valuable data. They made an analysis of 897 pulmonary emboli (343 fatalities) that occurred postoperatively. In about 25 per cent the emboli were manifest before the seventh day; in 50 per cent from the seventh to the fourteenth day and in 25 per cent after the fourteenth day.

At the New England Deaconess Hospital and the New England Baptist Hospital 550 major surgical operations resulted in 15 cases of pulmonary emboli (an incidence of 1.8 per cent). These operations were done by the Lahey surgeons.

In this series it was found that "patients over 50 years of age with arteriosclerosis and obesity when subjected to hysterectomy or herniotomy, are the most likely candidates for venous embolism. In a series of 57 cases of postoperative venous thrombosis treated by combined heparin and dicumarol, one subsequent pulmonary embolism and one fatal pulmonary embolism occurred."

Femoral vein interruption was first described by Homans in 1934. Allen, Linton and Donaldson[4] reported that between 1937 and 1942 they had treated 202 cases of thrombo-embolism; 12 of these patients died of pulmonary emboli. Some (probably most) of the thrombo-emboli followed operative procedures, but specific operations and the operative incidence for any surgical procedure are not given.

Linton[1] issued a more recent report which offers splendid encouragement for even severe embolic complications. In a thousand cases, there were only two deaths from pulmonary embolism, following bilateral femoral vein interruption.

PROPHYLAXIS

For some years now, I have been using sodium tetrathionate monohydrate † in terminal circulatory disturbances. Administration is simple, and the cost is little. This series of cases comprised a group of patients of various ages ranging from twenty to eighty-two. The complaint in most was either pain, tingling or numbness of the toes or fingers, sometimes involving parts of the feet or hands. There were no other apparent signs in most cases. In a few of the older patients arteriosclerosis was present. Almost without exception two or three intravenous injections of ten cubic centimeters of the sodium tetrathionate brought prompt and prolonged relief.

It was thought that if such conditions could be relieved perhaps the same drug might so im-

† Marketed under the trade name of *Tetrathione* (Searle).

2. Danforth, W. C.: American Journal of Obstetrics and Gynecology, 42:587 (October 1941).
3. Barker, N. W., *et. al.*: Proceedings of the Staff Meeting of the Mayo Clinic, 15:769 (December 4, 1940).
4. Allen, A. W., *et. al.*: Annals of Surgery, 118:728 (October 1943).

prove general circulation as to reduce the incidence of thrombo-embolus. This possibility was emphasized by the observation that in the last one hundred cases of conditions that are more prone to produce this complication, there were four such cases.

The list included two cases of phlebitis, one very mild. The other, more extensive, was discovered after the patient had been home several weeks. One pulmonary embolus occurred in a woman of seventy-six who had had a very uneventful course following a perineorrhaphy. Three weeks after the operation, she was stricken in her home and died. The fourth patient, a man of forty-six, developed a cerebral embolus ten days after operation, on his first day out of bed. He had some residual paralysis and sensory disturbances, but was fully recovered after seven months.

SODIUM TETRATHIONATE

Sodium tetrathionate monohydrate is an unstable substance having a tendency to decompose spontaneously to yield sulfur. In aqueous solution, the sulfur appears to be liberated first in a nascent or reactive form which then becomes a colloidol and finally forms actual crystals of sulfur. In this respect, sodium tetrathionate monohydrate is less stable than the sodium thiosulfate from which it is prepared. The medication is an active oxidizing agent, but just what effect it has on the body tissues is not known. Following the administration of sodium tetrathionate, there is an increase in the oxygen capacity and degree of oxygen saturation of the blood, a return to normal red color of oxygenated blood, a decrease in blood viscosity, a prolongation of coagulation time, a slowing of the sedimentation rate, an elevation of peripheral skin temperatures, a sense of warmth and relaxation, and a more normal ratio of oxidized and reduced glutathione. These are important considerations in the action of the drug.

ADMINISTRATION

Knowing that thrombophlebitis and embolus rarely manifest themselves before the fifth day, I arbitrarily selected the fourth postoperative day in my earlier cases. The first injection (the standard dose of 0.6 gram of sodium tetrathionate† in ten cubic centimeters of distilled water) was given intravenously. This was followed by daily injections for the next four days, making a total of five injections. The injections were therefore all given before the tenth postoperative day. Later, with early ambulation, the first injection was given on the second postoperative day.

Altogether the series included about 200 cases, representing 1000 injections. The only untoward effect was slight nausea. This was noticeable particularly when the injection was given on an empty stomach. A glass of water prior to injection would often eliminate the tendency to nausea. No other reaction immediate or latent followed in this series.

This point is especially emphasized, in view of an unfavorable report, in experimental work with animals, which was recently published by Gilman.[5] In this instance, doses far higher than those used clinically were administered to produce nephrotoxic effects.

In my earlier cases, the sodium tetrathionate was confined primarily to pelvic cases, especially hysterectomies. Later, however, it was administered to a more extensive group, including gall bladders, gastric cases, ventral herniae and all cases of a major character.

CASE REPORTS

In all, 237 cases were observed to date. Of these, in the first 86 cases from May 16 to October 31, 1945, 48 did not receive sodium tetrathionate. Among these 48 cases, four had complications of phlebitis or embolus. In the remaining 190 patients, who did receive sodium tetrathionate, three developed phlebitis, and another patient had phlebitis with pain in her left calf a day before the tetrathionate administration was begun. For all cases treated with tetrathionate, 40 belong to the group of age 50 and over. The remainder (namely 150) were under 50.

Hysterectomies *per se* or in conjunction with some other procedure totaled 75 cases. There were 37 additional pelvic and perineal cases. This represents a total of 112 cases out of 190 (about 59 per cent). There were 22 cases of cholecystectomy and common duct represent-

† Marketed under the trade name of **Tetrathione** (Searle).

5. Gilman, A. *et. al.*: American Journal of Physiology, 147:115 (Sept. 1, 1946).

ing, 11.5 per cent. Also there were 22 herniotomies, mostly incisional or complicated herniae. The complete list follows:

	Age		
	Under 50	Over 50	Total
Hysterectomy	70	6	76
Pelvic and perineal	30	8	38
Gall bladder surgery	18	4	22
Herniotomies	9	13	22
Carcinoma	3	2	5
Undescended testis	1	0	1
Intestinal obstruction	1	0	1
Childbirth	1	0	1
Prostatectomy	0	5	5
Gastric and duodenal	3	1	4
Nephropexy	3	0	3
Caesarean section	5	0	5
Appendectomy	4	0	4
Adhesions	2	1	3
Total	150	40	190

VENOUS COMPLICATIONS

The three patients receiving tetrathionate who developed phlebitis were as follows:

1. Age 46, white, female, was transfused for a marked anemia from a bleeding fibroid. Hysterectomy was performed August 26. The course was uneventful in the hospital after sodium tetrathionate. A few days after she arrived home (the 18th postoperative day) she developed phlebitis of the left leg. There were no embolic complications. She made a complete recovery after several months.

2. Age 53, white, female, developed a mild phlebitis of the right leg, ten days after operation. There were no embolic complications. She recovered in a few weeks with moderate swelling of the leg.

3. Age 72, white, female, had four operations. In January there was a repair of a cystocele, in February she had a repair for a vesico-vaginal fistula. Three days later she developed an intestinal obstruction due to postoperative adhesions from a hysterectomy done thirty years previously. A fecal fistula resulted with an incisional hernia. On September 23, the incisional hernia was corrected but in spite of receiving sodium tetrathionate, she developed a phlebitis of the left leg, from which she fully recovered without embolic involvement. She was given the tetrathionate after her first operation in January and had no phlebitis at that time.

Of the 190 cases treated with sodium tetrathionate there were only three cases of thrombophlebitis, an incidence of 1.6 per cent. No emboli were present although a number of patients were beyond 70 years of age. The list included some very extensive operative procedures and five malignancies.

By contrast, in the first hundred patients (of whom 48 did not receive sodium tetrathionate), there were two cases of thrombophlebitis and two of embolism, one fatal, among the untreated cases.

SUMMARY

The possibility of thrombophlebitis and embolism should be of prime consideration in every surgical case. Especially is this true in patients over 50 years of age, who have an operation of major proportion, particularly of the pelvis.

While thrombophlebitis is accepted as a common postoperative complication, the real danger is a possible embolism. Embolism still occurs in over one per cent of cases and is fatal in about one in every 520 cases.

Fatalities can now be materially reduced once embolism has developed. The prompt use of heparin and dicumarol have played an important role. Similarly, femoral vein interruption has been a life-saving measure in the more complicated cases.

From the standpoint of prevention, sodium tetrathionate (monohydrate) seems to offer some definite hope. While it would be folly to draw any final conclusions from a small series of 190 patients, it is interesting that no cases of embolism developed in this group. Furthermore the incidence of thrombophlebitis (three cases) represents a low incidence of 1.6 per cent.

CONCLUSIONS

1. All accepted procedures to prevent fatalities should be instituted promptly, once embolism has been diagnosed.

2. The two most valuable agents are the anticoagulants and femoral vein interruption.

3. Further study with a view of prevention of embolism should be continued.

4. Sodium tetrathionate monohydrate has proved itself as an agent worthy of further consideration as a prophylactic.

271 Lexington Avenue

STATE ACTIVITIES

1948 ANNUAL MEETING OF THE HOUSE OF DELEGATES
ABSTRACT

Prepared by EDITH L. MADDEN, Executive Assistant

1. Transactions of 1947 House of Delegates approved as published with the August, 1947 JOURNAL.

2. Reports of Officers and Committees (pages 164-203, April 1948 JOURNAL), approved as published with following specific recommendations:

a. Secretary—(1) That each component society organize a dignified membership drive. The goal: every recognized and reputable doctor of medicine should be in organized medicine.

(2) Since our representation in the A.M.A. is directly proportional to the number of Fellows of the American Medical Association in New Jersey, efforts should be made to insure that each member of the Medical Society become a Fellow of the A.M.A.

b. Treasurer—That future reports of the treasurer (presented at Annual Meetings) separate the accounts of the fiscal from the calendar year to provide a truer and more adequate picture of the Society's finances.

c. Military Service Committee—(1) That through THE JOURNAL and the component county societies, announcement be made of the need of the regular Army for physicians and of the opportunities and many inducements offered by the Army Medical Corps.

(2) That the military service committee meet at an early date to establish policies and proposals in the face of re-establishment of selective service with the possibility of induction of physicians.

d. Finance and Budget Committee—Budget for 1948-1949: $95,599. Dues for 1949, $24 per member; $5,000 of the dues to be set aside as a special reserve fund.

e. Medical Defense and Insurance — That the form acknowledging the risks of x-ray treatment be accepted with the proviso that the use of such form be left to the discretion of the individual physicians involved.

f. Board of Trustees—That the recommendation on medical attention at construction jobs be returned to the Board of Trustees for further study.

g. Legislative Committee—That the New Jersey delegates to the House of Delegates of the American Medical Association call upon the American Medical Association to oppose grants-in-aid to the states for health purposes unless such states are able to demonstrate a need for federal financial assistance.

h. Medical Service Administration of New Jersey—(1) That the state-wide plan for the control of payment for services rendered clients of the Old Age Assistance Board, the more liberal fee schedule of the Board of Child Welfare, and the approach on a county level be brought to the attention of all members of The Medical Society of New Jersey.

(2) That reference be made to the fee schedule of the Crippled Children Commission about remuneration of physicians for services rendered clients of the Crippled Children Commission of New Jersey; and that Dr. Scott meet with the Society's Crippled Children Committee to work out a solution to the problem.

j. Medical-Surgical Plan of New Jersey — (1) That we disapprove of the proposed merger of Blue Cross groups and Associated Medical Care Plan and formation of a National Insurance Company to promote sales of both plans nationally; that a representative be present at the meeting of the A.M.A. Council on Medical Service, and that the views of the members of The Medical Society of New Jersey be expressed on this matter.

(2) That the matter of a report from a "special committee to consider the inclusion of specialty medical service, (i. e., anesthesiology, radiology and pathology), in Blue Cross contracts" be brought before the Board of Trustees for further investigation.

k. Study of Medical Care—That this report be widely disseminated throughout the state and to the press, under the auspices of the Subcommittee on Public Relations.

3. Special matters considered by the House and recommendations adopted:

a. Crippled Children Commission and prosthetic appliances—That the federal Crippled Children Commission be asked to permit all Fellows of the American College of Surgeons to sign requests for prosthetic appliances, instead of restricting this to diplomates of the American Board of Orthopedic Surgery.

b. That the New Jersey delegates to the American Medical Association present a resolution through the A.M.A. requesting the federal government to allow all Fellows of the American College of Surgeons to sign requests for prosthetic appliances which are paid for by federal funds.

c. While we are in favor of the principle of low cost housing, the methods of achievements of this program are not primarily medical. We, as doctors, do not feel that we are qualified to evaluate the various legislative proposals for achieving that end. We recommend no action be taken on this matter.

d. To Dr. Jacob S. Wolfe, of Bloomfield, N. J.,

The Medical Society of New Jersey is happy to present a medal in recognition of his distinguished service to his patients, his community, his state and his profession. In so doing we honor Dr. Wolfe as an outstanding family physician and a good citizen.

e. In acknowledgment of a telegram from Dr. J. Lynn Mahaffey, at present ill in Cooper Hospital, conveying his appreciation of the Society's honor to Mr. William MacDonald; House recommended a note of thanks and sympathy in his illness be sent to Dr. Mahaffey.

f. That there should be a larger attendance at the meeting of the House of Delegates where final action is taken on so many vital and important matters; matter referred to the Board of Trustees.

g. That this House of Delegates go on record as holding its 183rd Annual Session in Atlantic City.

4. Amendments to the Constitution and By-Laws:

a. By-Laws amendments adopted:

Chapter VIII, Section 2, Standing Committees: Delete the words "Post-Graduate Education Committee" and substitute the words "Committee on Medical Education".

Chapter VIII, Section 11, Committee on Post-Graduate Education: Delete the present title and substitute the title "Committee on Medical Education".

Delete the words "Committee on Post-Graduate Education" in the first sentence and substitute the words "Committee on Medical Education".

Chapter VIII, Section 10, Welfare Committee: Delete the second line and substitute "not more than sixty members, exclusive of consultants, appointed annually".

Delete the fifth line from the end and substitute the words "Special Advisory Committees, of not more than fifteen members each".

Chapter VII, Section 4, Ethics and Discipline: Add the following sentence at end of paragraph "It shall also consider complaints of lay groups or persons against members of this Society".

Chapter V, Section 1, Nominating Committee: Delete the words "junior Past-President" and substitute the words "immediate Past-President".

Chapter V, Section 2, Procedure: Delete the words "junior Past-President" and substitute the words 'immediate Past-President".

b. Constitutional amendments:

First reading, final vote on amendment, 1949:

Article VI—Board of Trustees: Delete the words "junior past-president" and substitute the words "immediate past-president".

Second reading and final vote, adopted:

Article VI, Section 7, Emeritus Membership: "The emeritus membership group shall include physicians who have been members in good standing of a component county society for at least twenty years, and who by reason of age or infirmity have retired from active practice of medicine, or members of the society who have been disabled by reason of military service. They shall have all the privileges of membership except the right to vote and hold office, but their respective component societies shall not be assessed for such members provided they are carried as emeritus members in their component societies. The emeritus members shall not be included in the membership of a component society when computing the number of delegates that such society is entitled to."

5. Resolutions and Memorials adopted:

a. Biologic and Bacterial Warfare:

That whereas the employment of biologic and bacterial technics of warfare is inhumane in subjecting vast numbers of noncombatant inhabitants of combat areas to its jeopardies, now therefore

Be It Resolved, by The Medical Society of New Jersey that it declare its strong belief in the essential inhumanity of such technics of warfare and its further belief that those technics should be outlawed by international cooperative agreement, and

Be It Further Resolved, that our delegates to the American Medical Association be instructed to endeavor to have a resolution similar to this one adopted by that body.

b. World Health Organization:

Whereas, the World Health Organization of the United Nations is potentially one of the most important agencies in promoting world peace, as well as in safeguarding and enhancing world health and welfare, and

Whereas, the United States was a leader in the formation of the World Health Organization at San Francisco in 1945 and subscribed to the Constitution of the World Health Organization in New York in 1945, and

Whereas, in 1947, the United States Senate enacted a bill to make the United States a signatory to the World Health Organization and the Committee on Foreign Relations of the House of Representatives has approved a similar bill, and

Whereas, the Committee on Rules of the House of Representatives on March 12, 1948, by a divided vote placed this proposal indefinitely upon the table, thus preventing action by the House of Representatives, and

Whereas, more than the required minimum of twenty-six nations have become signatories to the World Health Organization and have thereby established this organization without United States participation, and

Whereas, if the recent action of the Rules Committee stands, the United States will be excluded from official participation in the formulation of world health programs and by its self-exclusion, the United States will deprive the World Health Organization of the considerable part of its necessary funds which were expected from the United States on the assumption that it would become a member thereof, and

Whereas, the World Health Organization has been approved and, to a degree, sponsored by the Ameri-

can Medical Association, the American Public Health Association, and virtually every other national health organization in the United States, therefore be it

Resolved, that The Medical Society of New Jersey record itself as earnestly favoring the adherence of the United States to the World Health Organization of the United Nations in the interest of promoting world peace, the advancement of health standards throughout the world, and the enhancement of the welfare of the United States, as well as all the United Nations; and be it further

Resolved, that The Medical Society of New Jersey urgently petition the Rules Committee of the House of Representatives to reconsider the report on the World Health Organization of the Committee on Foreign Relations to the end that, if possible, it be placed on the calendar for earliest possible action by the House of Representatives, and be it further

Resolved, that copies of this resolution be transmitted to each member of the Rules Committee, the Speaker and Majority Leader of the House of Representatives, the members of the House from the state of New Jersey, and the President of the United States.

c. Better School Health:

That it is premature to present this resolution on Better School Health Programs to the A.M.A. at this time and that no communication to the A.M.A. be issued on this matter at this time.

d. Medical Testimony in Compensation Courts:

That this matter be returned to the Board of Trustees for further study and subsequent recommendation to the State Society.

e. Special License Plates for M.D.s:

Whereas, there is a recognized parking and traffic problem for physicians engaged in professional activities, particularly in many urban areas of the state,

Therefore Be It Resolved, that the House of Delegates request the Commissioner of Motor Vehicles to issue specially marked automobile license plates to doctors of medicine.

f. Survey Committee on Medical School in New Jersey:

Whereas, the standards of medical practice, and consequently, the health level of a community are elevated by the existence of an approved medical school in the area in which it serves, and

Whereas, there is at present no medical school in New Jersey, and

Whereas, collegiate educational facilities of all kinds, except in medicine and dentistry, are available to the people of this state, and

Whereas, many physicians, educators, and influential members of the lay public have long believed that a medical school is needed in New Jersey, and

Whereas, unless new or additional facilities are developed for the education of a large number of physicians there may be a serious shortage of medical personnel by 1960, and

Whereas, the State University at Rutgers is at the present time expanding existing and adding new facilities for collegiate education and is considering general aspects of the problem of establishing a medical school, and

Whereas, a high grade medical school can only be developed with wholehearted cooperation on the part of the medical profession in the area in which it is to be established, and

Whereas, the Board of Trustees of The Medical Society of New Jersey has endorsed the principle of an approved medical school under university auspices and supported by general tax funds, therefore be it

Resolved, that The Medical Society of New Jersey propose to the Governor that the Society assume leadership in the study of all matters relating to the need for, the development and the operation of an approved medical school, and be it further

Resolved, that The Medical Society of New Jersey hereby propose to the Governor the establishment of a representative study committee and recommend to him that it be composed of 16 members to be appointed as follows: (1) that The Medical Society designate four of its members; (2) that The Medical Society invite Rutgers University to appoint four additional members; and (3) that The Medical Society request the Governor of New Jersey to appoint eight additional members from among leading lay citizens, and be it further

Resolved, that this Survey Committee shall be commissioned by him to investigate and study the requirements for successful completion of this project, and, upon completion of its study, it shall make known its recommendations to the Governor and the Legislature.

g. Appreciation to Senator H. Alexander Smith, New Jersey:

Whereas, the junior U. S. Senator from New Jersey, the Honorable H. Alexander Smith, is chairman of the Subcommittee on Health of the Senate Committee on Education and Labor, and

Whereas, Senator Smith's Subcommittee is studying bills for a national health program, including S.545, the Taft-Smith-Ball-Donnell Bill, and S.1320, the Wagner-Murray-Dingell Bill, and

Whereas, Senator Smith, desiring to obtain an alternative report on compulsory health insurance from an unbiased source, induced the Brookings Institution to prepare a study of this subject, and

Whereas, the report of the Brookings Institution recently published supports and substantiates the objections to national compulsory health insurance which have for years been stated by the medical profession, and

Whereas, this report provides a major vindication of the viewpoint of the medical profession on this subject, therefore be it

Resolved, that The Medical Society of New Jersey express its appreciation to U. S. Senator H. Alexander Smith of New Jersey for his statesmanlike approach to the problem of compulsory health

insurance in initiating the study of this subject published by the Brookings Institution.

h. Senate Bill 148, County and "part-county" Health Districts:

Whereas, the platform of the American Medical Association, adopted in June 1944, declared in part: "There is great need for the increase of county or district departments of health. . . . Every area in the United States should have a health service with adequate personnel and facilities. . . . It should be integrated with and coordinated by the state health department," and

Whereas, Chapter 177 of the Laws of 1947, State of New Jersey, reorganized the State Department of Health and conferred upon it the authority to

> "Require local boards of health to establish and maintain a program of recognized public health activities and to meet minimum standards of performance as prescribed by the Public Health Council. . . . ", and

Whereas, it is impossible for any central authority to require any but a few of the 566 local boards of health to "establish and maintain a program of recognized public health activities" as long as the majority of these local health districts have populations of less than 2500 each to support their local health services, and

Whereas, health and medical authorities have unanimously approved pending Senate Bill 148 to enable local communities in the fourteen smaller counties to combine their health services in county or part-county health departments, therefore be it

Resolved, that The Medical Society of New Jersey hereby urgently request the Legislature and Governor to enact S.148, as an essential step in providing modern high quality health protection to the people of New Jersey.

j. Disposition of State Board of Medical Examiners:

Whereas, The Medical Society of New Jersey is rightly proud of the 58 year record of the New Jersey State Board of Medical Examiners in the elevation of standards of medical education and practice in this state, and

Whereas, The Medical Society of New Jersey has recommended, sponsored, worked for every progressive legislative enactment to elevate the standards of medical licensure and to support or further the work of the State Board of Medical Examiners, and

Whereas, The Medical Society of New Jersey believes that it is essential to insure that the State Board of Medical Examiners be kept free of political entanglement or interference in its vital function of protecting the public welfare in matters of medical practice, and

Whereas, The state Administration has proposed, in Senate Bill 23, to place the State Board of Medical Examiners, together with other professional licensing boards, under the supervision and control of the Secretary of State in an expanded Department of State, and

Whereas, this proposal would effectively destroy the integrity and autonomy of these professional boards by subjecting the State Board of Medical Examiners to the domination of an officer not qualified by training to so function, and

Whereas, the disposition of the State Board of Medical Examiners, and its companion boards, as proposed in S.23 cannot be justified on the grounds of efficiency, economy or logic, and

Whereas, eleven of the professions * represented in eight of the examining boards have unanimously protested this proposal, and unanimously recommended that these boards be placed together in a separate principal Department of Professional Boards, therefore be it

Resolved, by The Medical Society of New Jersey, that we hereby make known our unalterable opposition to that part of Senate Bill 23, and that we oppose it with all the influence at our command; that we condemn the proposal to subject the State Board of Medical Examiners to the supervision and control of a governmental agency operated by a non-professional officer of the State, that we emphasize the fundamental necessity, in the public interest, of maintaining the professional integrity and the administrative autonomy of the State Board of Medical Examiners and comparable professional boards, that we reiterate our well considered alternative proposal for a separate Department of Professional Boards; and that we urgently solicit the support of all other agencies and persons concerned with the maintenance of standards of medical licensure in New Jersey in defeating the dangerous and insupportable principles embodied in that portion of S.23 and be it further

Resolved, that copies of this resolution be sent to the Governor, to all members of the State Legislature, to the press, and to all cooperating agencies in the field of public health and welfare.

k. Life Insurance Examination Fees:

Resolved, that The Medical Society of New Jersey approve an increase in the medical fees for a regular life insurance examination to $10, with other medical insurance fees to be increased in like proportion, and be it further

Resolved, that the delegates of this society to the A.M.A. be instructed to try to have the A.M.A. take action consistent with this resolution.

m. Bureau of Child Health and Health Education, A.M.A.:

Whereas, the American Medical Association held the first national school health conference in 1947, and included in its third rural health conference in 1948 the health and medical care problems of rural children, and

Whereas, state and county medical societies, having child health committees and programs, have need of guidance and assistance at national levels for their child health programs by having a specific bureau of the American Medical Association responsible for children,

Therefore Be It Resolved, that The Medical So-

* Architects, chiropodists, doctors of medicine, dentists, veterinarians, public accountants, nurses, pharmacists, optometrists, chiropractors and osteopaths.

ciety of New Jersey request that the House of Delegates of the American Medical Association add the words "Child Health" to the title of the present Bureau of Health Education, to read "The Bureau of Child Health and Health Education", in order that this excellent and helpful Bureau may definitely be regarded by county and state medical societies as the coordinating center in the Association for the study and evaluation of the many types of child health and medical care programs being evolved by governmental, medical, and voluntary agencies in this country.

n. Services of Hilton S. Read, M.D.:

Whereas, Hilton S. Read, M.D., has for thirteen years served as a delegate to the American Medical Association, and during that period has traveled to the four corners of the nation in the interest of this society, laboring indefatigably and effectively on behalf of his fellow practitioners, and

Whereas, he has for eight years served as chairman of the Welfare Committee, performing that important function with grace, adroitness and consummate skill, and

Whereas, he has refused any consideration at this time for further office within The Medical Society of New Jersey,

Therefore Be It Resolved, that The Medical Society of New Jersey hereby places on record its appreciation of the long, loyal, and creditable service rendered to it by Dr. Read, and

Be It Further Resolved, that a copy of this resolution be transmitted to the press, that the text be spread on the minutes of the House of Delegates and published in its *Transactions,* and that a copy signed by the President of this Society be personally transmitted to Dr. Read.

p. Services of Thomas B. Lee, M.D.:

Whereas, Thomas B. Lee, M.D., has for almost two decades served as a Trustee of The Medical Society of New Jersey, and

Whereas, during that period he was a faithful member of the Board, attending meetings regularly, year in and year out, often at great personal inconvenience, and

Whereas, he was always an alert, active and effective member of the Board, one who had served as its chairman with grace, distinction and impartiality, one whose wise and mature counsel consistently proved a tower of strength and a source of inspiration to his fellow trustees, and

Whereas, having sacrificed so much of himself and his health in the service of his fellow practitioners, he now finds it necessary to retire from the office he has held with such honor, now

Therefore, Be It Resolved, that The Medical Society of New Jersey hereby places on record, its appreciation of the long, loyal and creditable service rendered to it by Dr. Lee

And Be It Further Resolved, that a copy of this resolution be transmitted to the press, that the text be spread on the minutes of the House of Delegates, and published in its *Transactions,* and that a copy signed by the President of this Society be personally transmitted to Dr. Lee.

q. Services of S. Emlen Stokes, M.D.:

Whereas, during a period of several years, S. Emlen Stokes, M.D., has served with distinction and tact in the difficult office of Judicial Councilor of The Medical Society of New Jersey, and

Whereas, Dr. Stokes now finds it necessary to withdraw from further service in that capacity, now

Therefore, Be It Resolved, that this House go on record as noting with regret Dr. Stokes' decision to retire from further service as a Judicial Councilor, and that this House, as a token of appreciation for the many years of service, so honorably and faithfully rendered, hereby spread on its minutes this memorial of appreciation and gratitude, and

Be It Further Resolved, that a copy of this resolution, signed by the President of The Medical Society of New Jersey, be personally delivered to Dr. Stokes, and that other copies be released to the press and recorded in the *Transactions* of this 1948 Annual Meeting.

r. Services of Lancelot Ely, M.D.:

Whereas, among the small and honorable company of Fellows of The Medical Society of New Jersey, one of the most distinguished is Lancelot Ely, M.D., and

Whereas, after many years of faithful service as an alternate delegate to the American Medical Association, Dr. Ely finds it necessary to retire from such service, and

Whereas, in his capacity as alternate delegate, Dr. Ely consistently, effectively and creditably, labored for the interests of the people and profession of New Jersey,

Now Therefore, Be It Resolved, that The Medical Society of New Jersey hereby place on record its appreciation of this distinguished service, and

Be It Further Resolved, that the text of this resolution be transmitted personally to Dr. Ely and that a copy thereof be spread on the minutes of this House.

s. Death of Charles H. Schlichter, M.D.:

Whereas, Almighty God in his wisdom has seen fit to call our esteemed colleague, Dr. Charles H. Schlichter to his eternal reward, and

Whereas, Dr. Schlichter has for many years contributed of his time and energy unselfishly in the interest of the medical profession as a citizen, as a member of this Society and as a member of this House of Delegates, and

Whereas, Dr. Schlichter has been, not only an outstanding physician, but a man whose conduct of life has set a pattern which might well be emulated by all of us, and who has gained the respect and love of all people with whom he has come in contact as a friend or colleague,

Therefore, Be It Resolved, that this House of Delegates in Assembly at its Annual Meeting this date express its deepest sorrow for the passing of its esteemed member, and express to the bereaved family its deepest sympathy.

Be It Further Resolved, that this Resolution be spread upon the minutes of this meeting and that

a copy of this Resolution be sent to his faithful companion for over 50 years, Mrs. Schlichter.

t. Veterans Medical Care:

Whereas, it has been called to the attention of individual members of this committee that certain veterans suffering with service connected and non-service connected disabilities requiring hospitalization are experiencing difficulty in obtaining admission to hospitals, and

Whereas, this committee has a sincere interest in the welfare of the veteran and in his efforts to obtain adequate medical care, therefore be it

Resolved, that efforts be made to assist these veterans by instructing them to communicate with their respective county society committees through any physician who will inform them of the name of the secretary of the county society, who, in turn, will make contact with the proper member of the county committee who will make every effort to assist such veterans, and be it further

Resolved, that this effort on the part of this Committee be given publicity through the press and through all service organizations and health agencies which may know of such cases among veterans.

u. Senate Bill 171—Optometry:

Whereas, committee substitute for Senate Bill No. 171 proposes for the first time in the history of New Jersey to convert a vocation or occupation into "a learned profession", and

Whereas, optometry is a mechanical art but is not a learned profession comparable to law, medicine and theology, and

Whereas, the honor and nobility of the "learned profession" is not a mantle one places upon his own shoulders, but is gained by public recognition, the result of achievement and attainment by honor and respect, and

Whereas, section VII of this bill attempts to take away from the court the power to determine the qualifications of an optometrist to testify as an expert, and

Whereas, a further provision of this section which requires certificates issued by optometrists to be accepted as qualified evidence, deprives a part of his right to examine their qualifications; deprives the judge and the jury of personal observation of witnesses and their manner of testifying, both of which are highly important in deciding as to the credibility and weight of the testimony, and

Whereas, there is no statute in this state dealing with any profession which incorporates such a provision as this or one comparable thereto, and

Whereas, the balance of section VII requiring state, county and municipal departments and agencies, to accept services of registered optometrists, represents a direct attempt in a new and different way to foster and stimulate business through legislation, rather than through merit, and

Whereas, the use of the words "on a parity with any other person authorized by law to render similar professional services when such services are needed, and shall pay for such services in the same way as other professions may be paid for similar services" is an indirect attempt to place optometrists through legislation on a par with the learned professions, and

Whereas, it is a sad commentary on any calling that recognition and respectability which should be acquired through reputation and merit is to be acquired by legislation, therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey hereby records its opposition to Senate Bill No. 171 and urges its rejection by the New Jersey Legislature, and be it further

Resolved, that copies of this Resolution be forwarded to all members of the House of Assembly.

6. *Honorary Membership:* Mr. William H. MacDonald, Chief, Local Health Division, New Jersey State Department of Health, elected to Honorary Membership in The Medical Society of New Jersey, in recognition and appreciation of his many years of assistance to and cooperation with our Society.

7. *Emeritus Membership:* The following were elected to Emeritus Membership in The Medical Society of New Jersey and nominated to Affiliate Membership in the A.M.A.

Dr. William Flitcroft	Passaic County
Dr. Clara K. Bartlett	Atlantic County
Dr. Henry E. Woelfle	Hudson County
Dr. J. Phillip Stout	Hudson County
Dr. George H. Sexsmith	Hudson County
Dr. Samuel Selinger	Hudson County
Dr. James H. Rosecrans	Hudson County
Dr. Wallace Pyle	Hudson County
Dr. Benjamin Older	Hudson County
Dr. Thomas D. Keegan	Hudson County
Dr. Hugo Gille	Hudson County
Dr. John Connell	Hudson County
Dr. David R. Atwell	Hudson County

8. *Election:*

Office	Term
President—	
J. Howard Hornberger, Roebling	1 year
President-elect—	
James F. Norton, Jersey City	1 year
First vice-president—	
Aldrich C. Crowe, Ocean City	1 year
Second vice-president—	
Sigurd W. Johnsen, Passaic	1 year
Secretary—	
Earl LeRoy Wood, Newark	1 year
Treasurer—	
George J. Young, Morristown	1 year
Trustees:	
Second District...J. Lawrence Evans, Woodcliff	3 years
Third District....L. Samuel Sica, Trenton	3 years
Fourth District...Reuben L. Sharp, Camden	3 years
Fifth District.....David W. Green, Salem	3 years
Councilors:	
First District.....Francis C. Weber, Newark	3 years
Fourth District...Daniel F. Featherston, Asbury Park	3 years
A.M.A. Delegates and Alternates:	
Delegate.....J. Wallace Hurff, Newark	2 years
Alternate.....Elmer P. Weigel, Plainfield	2 years

Office		Term
Delegate	David B. Allman, Atlantic City	2 years
Alternate	William E. Bray, Pemberton	2 years
Delegate	Thomas K. Lewis, Camden	2 years
Alternate	Clarence W. Way, Sea Isle City	2 years

Delegates and Alternates to Other States:

Delegate to Conn.	Alfred Stahl, Newark	1 year
Alternate to Conn.	C. Byron Blaisdell, Long Branch	1 year
Delegate to N. Y.	James F. Norton, Jersey City	1 year
Alternate to N. Y.	D. Ward Scanlan, Atlantic City	1 year

Standing Committees:

Finance, Budget	Herschel Pettit, Ocean City	6 years
Publication	Henry C. Barkhorn, Newark	3 years
Scientific Work	Harold S. Davidson, Atlantic City (5th Dist.)	5 years

RECOMMENDATIONS IN REPORTS OF COMMITTEES ADOPTED BY HOUSE OF DELEGATES, APRIL, 1948

Advisory Committee on Anesthesiology (page 193, April JOURNAL).

1. That directives again be forwarded to the responsible heads of all institutions informing them that the practice of anesthesia has been adjudged by the American Medical Association to constitute the practice of medicine. The same stand has been taken by The Medical Society of New Jersey.

2. That the directors of the Medical-Surgical Plan consult with the incoming members of the Advisory Committee on Anesthesia so that, if possible, a revised fee schedule dealing with anesthesia may be adopted which will be satisfactory to all parties concerned.

Advisory Committee on Medical Care of the Indigent (page 196, April JOURNAL).

That Medical Service Administration of New Jersey, now operating the City of Newark Medical Plan, be consulted by any county society which believes that a project similar to the City of Newark Plan might be inaugurated within its county.

Advisory Committee on Radiology (page 198, April JOURNAL).

That during the next year every effort be made to correct this illegal practice of medicine by the Blue Cross Plan (selling the services of the radiologists is practice of medicine by a corporation).

a. That the Medical Practice Committee study the actuarial soundness of the present Blue Cross contract in regard to the hospital.

b. That a committee be delegated to meet with a committee from the hospital association, the Blue Cross Plan and the Commissioner of Insurance to study ways of correcting this illegal practice of medicine, to remove from the hospitals and the radiologists this unjust financial obligation which has been imposed on them by the present Blue Cross contracts and to form a simply worded contract which will not permit of ambiguous interpretation.

Supplementary Report of Medical-Surgical Plan.

1. A higher subscription rate.

2. A higher income level for inclusive services.

3. A higher schedule of benefits and payments by the Plan to physicians.

Supplementary Report of New Jersey Health Congress.

To strengthen the essential voluntary approach at county levels in New Jersey toward making good quality medical services widely available to every citizen, The Medical Society of New Jersey requests each component county medical society to appoint a strong committee or council on medical services, as part of its program of good public relations; the committee's membership should include the chairman of the Medical Practice Committee and the chairman of the Public Relations Committee and they should make definite plans to see that good quality medical services are made available to every man, woman, and child in the county, with particular attention to the medical needs of persons in low income families.

Supplementary Report of Committee on Medical Defense and Insurance.

Renewal of the professional liability contract with the U. S. Fidelity and Guaranty Company through the Official Broker, Faulhaber & Heard, Inc., Newark.

Renewal of the Accident and Health contract with the National Casualty Company through E. & W. Blanksteen.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

Ask each patient you admit to a hospital: "Are you enrolled in Medical-Surgical Plan of New Jersey?"

When a patient, not entitled to full service benefits in accordance with the Schedule of Benefits of the Plan, requests the services of a Participating Physician, the patient and physician should agree in advance on the amount of the total fee.

The Board of Trustees of the Plan believes that the patient is entitled to know the cost of a physician's service at the time the service is requested.

NORMAN M. SCOTT, M.D.

WELFARE COMMITTEE

MAY 23, 1948

The Welfare Committee met at the Society Headquarters, Trenton, on May 23, 1948. Under the chairmanship of Dr. Vincent P. Butler, and with 38 members, officers and guests present, the committee took the following actions.

Heard a short talk from President Hornberger in which the need for consistent attendance at committee meetings was stressed.

Heard a review of the rural health program of the Woman's Auxiliary. This was reported by Mrs. Asher Yaguda, Auxiliary Public Relations chairman.

Heard a report by Dr. Scott on medical attendance to clients of the Old Age Assistance Board and the Board of Child Welfare. (See page 362 this issue.)

Approved the report of the Subcommittee on Legislation. This report is published in abstract below.

Approved the recommendations of the Subcommittee on Medical Practice as published on page 349 of this JOURNAL.

Approved items 1, 2 and 4 in the report of the Subcommittee on Public Health. (See page 350 of this JOURNAL.)

Approved the report of the Subcommittee on Public Relations (see page 350).

SUBCOMMITTEE ON LEGISLATION

(Abstract of the report of May 23, 1948)

The most important single legislative subject remaining as unfinished business is the disposition of the State Board of Medical Examiners and other professional licensing boards. Senate Bill 23 would place the professional boards in the Department of State. Governor Driscoll, we are informed, requested that no further action be taken until he had had an opportunity to sit down with representatives of the various professions and see if something could not be worked out.

The New Jersey Council of Professions, which includes representatives of the professions concerned, is firmly of the belief that the most logical disposition of this would be establishment of a single principal Department of Professional Boards, to be administered by a council of representatives of the professional licensing boards as the head of such a department. While we continue to advance this proposal, nothing has occurred thus far to make us sanguine that such a department will be created.

If this cannot be brought about, probably the best alternative would be the establishment of a Division of Professional Boards in the Executive Department itself, directly answerable, as is now the case, to the Governor.

The optometry bill (S-171) was amended so that this group was not recognized legislatively as a "learned profession". The bill does not admit that optometry is a profession. The bill was further amended so that the entire Section 7 was eliminated. This section would have qualified as expert optometrists in any litigation in which they testified, and would have made it necessary for any department or subdivision of the state, to have recognized optometrists on a parity with the ophthalmologists. The bill, with the amendments as described, was passed on May 12 and is now awaiting action by the Governor.

On April 26, a bill to create a separate board of chiropractic examiners, A-467, was introduced. A large number of legislators feel that "something should be done for the chiropractors". It is to be remembered that the complexion of the Legislature constantly changes. This has been notably true of the Assembly. The fact that under the new Constitution the terms of the Assemblymen are now two years, and the fact that the salaries of the legislators have been raised from $500 to $3000 may slow down this turnover somewhat. What it has meant has been the reeducation of the legislators on the chiropractic situation almost every year or two.

The chiropractic bill this year initially demonstrated considerable support. In caucus of the majority party it received 28 votes and was reported out of committee. Intensive work especially on the part of legislative keymen and county society officers, and visitation by delegations from several counties to the Assembly Chamber changed the situation considerably. On May 12, at a caucus of the majority party, this bill received somewhere between 11 and 14 votes, as compared with 28 votes a short time previously.

The bill to create a separate chiropractic board, A-467, is not dead. It is on second reading in the Assembly and it is conceivable

that it could be advanced to third reading after the legislative recess. Likewise, the assembly concurrent resolution with respect to a survey is still alive and remains on second reading in the Senate.

A committee consisting of Doctors Hurff, Taber and the Executive Secretary, Dr. Quigley, was appointed to have drawn an alternative joint resolution which will provide for a survey of chiropractic by a Commission to consist of a committee of Rutgers University to be appointed by the President of Rutgers. After approval by the Committee on Legislation, it is proposed to have this alternative resolution introduced in the Legislature after it returns from its recess August 16.

The administration bills, Committee substitutes for S-147 and A-28, to provide cash sickness benefits, were passed by the Legislature.

A bill, A-517, sponsored by the chiropodists provides certain clarifying amendments. We have not seen them yet, but are certain that any suggestion we may have to make will be accepted by the chiropodists.

There are two subjects which will be before the Committee during the fall for study and probable action: (1) the licensing of commercial laboratories, and, (2) licensing or certification of psychologists.

The measure introduced at this session to license medical technologists makes fairly definite that the only licensing that is really needed is that of commercial laboratories. We shall endeavor, in conjunction with the Advisory Committee on Laboratory Medicine, to evolve a measure which will take care of the situation.

The New Jersey Neuropsychiatric Association feels that legal recognition should be given to psychologists. We shall endeavor to work out, with the cooperation of the psychologists and the Association of Neuropsychiatrists, suitable legislation. Our Board of Trustees is on record as favoring such licensing if it is to be done by the State Board of Medical Examiners.

The New Jersey State Association of Anesthetists are seeking legal recognition. This proposition will also receive our attention.

Since our Supplemental Report to the House of Delegates, the only matter of national legislation called to our attention is H.R. 3934. This proposes to amend the Public Health Service Act with respect to Venereal Disease Rapid Treatment Centers. We are advised that the federal grants presently being received are sufficient for this purpose in New Jersey. This bill (H.R. 3934) not only proposes additional funds for this purpose, but would make appropriations possible for "clothing of persons afflicted with venereal disease", "reasonable expenses of preparing the remains, and of burial of deceased patients", "furnish repairing and cleaning of wearing apparel prescribed by the Surgeon-General for use of the employees in the course of their official duties", "recreational supplies and equipment". At the suggestion of the Director of the Washington office of the A.M.A., we have written to Congressman Wolverton of New Jersey, protesting this measure. Congressman Wolverton is Chairman of a subcommittee which heard arguments on this bill. This bill is a shining example of possible perversion of public health legislation, and while it is an extreme example, it is not an isolated case.

SUBCOMMITTEE ON MEDICAL PRACTICE

MAY 23, 1948

The following recommendations were adopted at the meeting May 23, 1948, and were later approved by the Welfare Committee:

Memorandum to Delegates to the A.M.A. Convention: The collection of blood by the American Red Cross has come to our attention. We understand that the state of California has come out openly in respect to some phases of the project. So far as this Committee is concerned ,we do not *per se* know all the ramifications of the project at this moment, but it is the sense of this Committee that the matter should be looked into at the sessions of the A.M.A. Convention. Any project of this sort should acknowledge the principle that the collection of blood is an essentially scientific undertaking and should therefore be under the supervision of the medical profession in cooperation with the Red Cross of the state. We accordingly recommend that a committee be appointed by the A.M.A. to work in cooperation with the Red Cross in order to arrive at a plan that will be feasible.

It is recommended that the Delegates to the A.M.A. Convention be instructed to oppose all forms of hospital practice of medicine and we recommend and that the A.M.A. take all steps within its power to counteract the tendency of hospitals to encroach upon the private practice of medicine.

SUBCOMMITTEE ON PUBLIC HEALTH

MAY 23, 1948

The following matters were discussed at the May 23 meeting of the subcommittee on Public Health:

1. Use of penicillin instead of silver nitrate in the eyes of the new born.

The Advisory Committee on Conservation of Vision was requested to study this matter and present a report and specific recommendations at the next meeting of the Subcommittee.

2. Dr. Blaugrund named the following as a special committee to implement Public Health Week (November 8th, 1948):

Dr. S. William Kalb, Chairman
Dr. C. Byron Blaisdell
Dr. Daniel Bergsma
Dr. Henry A. Cotton
Dr. Harrold A. Murray
Dr. Stanley Nichols
Mrs. Robert B. Walker

3. Introduction of courses in sex education in the public schools in New Jersey, under the auspices of the Advisory Committee on Venereal Disease Control.

4. Development of public health programs on a local and county level.

SUBCOMMITTEE ON PUBLIC RELATIONS

MAY 23, 1948

At its meeting on May 23, 1948, the Subcommittee adopted the definition of public relations drawn from the formulation worked out by the editors of *Public Relations News*. The definition is:

> "*Public Relations* is the management function which evaluates public attitudes, identifies the policies and procedures of an individual or an organization with the public interest, and executes a program of action to earn public understanding and acceptance."

Mr. Bryan presented an agenda of proposed conferences with officers of county societies and for later visits to county society meetings embodying eight approved programs on which county medical society assistance and action are needed. The Subcommittee decided to hold a public relations conference with officers and public relations chairmen of the county societies in Trenton on June 13. A program for this conference was reviewed and approved. Among the matters to be discussed at this conference is the organizational set-up of the county societies. We want to make certain that all county societies have a public relations committee or its equivalent.

The committee considered proposals for a speakers' bureau. It was decided to set up a unit of the Subcommittee on Public Relations, consisting of Dr. Murray, Dr. Wikoff and Miss Rogers, who will survey the county societies to find out which of them have speakers' bureaus and how they operate. The Subcommittee will then develop suggested plans to propose to other county societies for organizing a speakers' bureau service.

Emphasis was placed on making speakers available for school assemblies.

The committee decided to sponsor a contest for school essays on the topic "What Are the Essentials of a Good School Health Program?" The proposal is to be taken up with the State Education Department with the hope that it will be jointly sponsored by the Department and The Medical Society. Local interest will be aroused through the school health council in each county. The committee proposes to offer two $50 prizes for the state winners in grammar schools and high schools. It is proposed that the $100 needed for this project be obtained by transfer from the committee's budgetary item for pamphlets and publications.

The committee received a report on the New Jersey Health Congress by Dr. Nichols. He hoped that each county society would have a public health committee and should take the initiative in setting up a county public health council. This proposal was approved in principle.

BOARD OF TRUSTEES

APRIL 26, 1948

The Board of Trustees held a meeting in Atlantic City on April 26, at which the following actions were taken:

1. Minutes of March 14 meeting approved as distributed.

2. Report of Special Committee on Cash Sickness Benefits approved.

a. That The Medical Society of New Jersey endorses the principle of cash sickness benefits.

b. That the policy of The Medical Society of New Jersey, in relation to cash sickness benefits, is that no legislation should be enacted which might allow government to intervene in the employment relationship.

c. That a permanent committee be appointed for the study of cash sickness benefits.

3. Report of the Legislative Committee on Cash Sickness Benefits, as adopted by the Welfare Committee on March 7, approved.

4. Resolution on Committee Substitute for S-171 (Optometry Bill) urging members of Assembly to reject measures, approved.

5. Recommendations and Resolutions referred to House of Delegates:

a. Resolution on S-23 and disposition of the New Jersey State Board of Medical Examiners.

b. Resolution on World Health Organization.

c. Resolution on S-148, County and Part-County Health Districts.

d. Resolution on Survey Committee on Medical School in New Jersey.

e. Communication from General Hodges, U. S. Army, on current shortage of physicians, dentists and nurses in military service.

f. Communication from A.M.A. Council on Medical Service on proposed merger of American Medical Care Plans and Blue Cross Plans, and development of national insurance company.

g. Proposed amendments to By-Laws on Committee on Post Graduate Education.

h. Ruling of Crippled Children Commission about signature on forms for purchase of prosthetic appliances for their clients.

i. Resolution on increase in Life Insurance Examination Fees.

j. Proposed amendments to By-Laws concerning membership on Welfare Committee and Special Advisory Committees.

k. Recommendation of Welfare Committee about plan for medical attention at construction jobs.

l. Nomination for Emeritus Membership in the State Society and subsequent nomination for Affiliate Membership in the A.M.A.

m. Resolution about state and county better school health committees.

n. Resolution on A.M.A. Bureau of "Child Health" and Health Education.

o. Communication from New Jersey Housing Council.

6. Requests for the establishment of four new sections, approved with recommendation:

That the Board endorse in principle the establishment of sections in all branches of medicine and surgery; the Annual Meeting Committee and its Subcommittee on Scientific Program to plan the utilization of these sections during the Annual Meeting; and that, if necessary, section programs be presented at regular intervals throughout the year, thus developing a greater interest in the activities of the Society.

7. Subscription for complete coverage of the National Health Assembly, by Mr. Edward F. Stegen, at cost of $100, approved.

8. Nominated Dr. William F. Costello for the Board of Trustees of Medical-Surgical Plan and Medical Service Administration to fill the vacancy caused by death of Dr. Knight; and nominated present members of Boards of Trustees of Medical-Surgical Plan and Medical Service Administration for re-election.

9. Report of General Practitioner Award Committee with following recommendations approved:

a. Nomination of Dr. Jacob S. Wolfe, Bloomfield, as recipient of award for 1948; and gold medal appropriately engraved for presentation to him.

b. For future awards, that the Committee be appointed early in the year so that ample time can be devoted to nominations; that more publicity be given to award throughout the county societies; and that a permanent emblem be decided upon.

10. As to the recommendation of Advisory Committee on Nutrition, "that colleges and universities of this state require public health education as a part of entrance requirements," it is believed that further study is needed before a specific program can be formulated. This is referred to the Advisory Committee for further detailed study.

11. Approved Mr. Bryan's reemployment as Executive Officer for fiscal year, 1948-49.

BOARD OF TRUSTEES

APRIL 29, 1948

The Board of Trustees held a re-organization meeting in Atlantic City on April 29, 1948. An abstract of the actions of that session follows:

1. Dr. L. Samuel Sica of Trenton was elected chairman for 1948-49.
2. Dr. Elton W. Lance of Rahway was elected secretary for 1948-49.
3. Employment of all salaried personnel was continued for 1948-49 at previously established salaries.
4. The resignation of Dr. J. Lawrence Evans of North Bergen, as a member of the Publication Committee was received; appointment of successor was deferred until next meeting of Board.
5. Dr. Crowe, Dr. Johnsen and Dr. Green were named as a special committee to give further study to the resolution on medical testimony referred to the Board by the House of Delegates.
6. The recommendation on medical attention at construction jobs (received back from the House of Delegates) was referred by the Board to its source, the Advisory Committee on Workmen's Compensation, for further study.

BOARD OF TRUSTEES

JUNE 6, 1948

The Board of Trustees held a regular meeting in Trenton on June 6, 1948. An abstract of the actions follows:

1. Minutes of April 26 and 29, 1948, meetings were approved as distributed.
2. Considered a resolution on veterans' medical care.
3. Veterans Liaison Committee named a review committee for the Veterans Administration, with power to handle matters as they arise.
4. The contract and fee schedule with the Veterans Administration, effective July 1, 1948, was approved and signing authorized.
5. A.M.A. Delegates were instructed to procure full information on the subject of collection of blood by the Red Cross and go to A.M.A. convention prepared to present a program along the lines of the following approved principles:

a. Blood banks are desirable.
b. Blood banks should not be turned over to the Red Cross on a national basis.
c. Blood banks should be based on cooperation between organized medicine and the Red Cross.
d. Methods of administration of blood banks should be settled on a purely local level.
e. The Red Cross should not be permitted to operate blood banks without the approval of and collaboration with organized medicine in the community in which the blood bank is to be operated.

6. A.M.A. Delegates were instructed to oppose all forms of hospital practice of medicine; also to request A.M.A. to take all steps within its power to counteract the tendency of hospitals to encroach upon the private practice of medicine.
7. President Hornberger was authorized to name a committee consisting of an orthopedic surgeon, pediatrician, neurologist, psychiatrist and an internist to work as a general medical advisory committee with the National Society of Crippled Children and Adults, as requested by that organization.
8. The president was empowered to name a county society officer, who is attending the A.M.A. convention, to represent New Jersey at the Conference of County Medical Society Officers.
9. The president was authorized to forward a copy of the resolution of the House of Delegates on the Commission to study ways of establishing a medical school in New Jersey to the New Jersey Welfare Council. This is in response to their expression of support of the Society's stand on this matter and their request for an opportunity to study the Society's recommendations and criteria on the subject.
10. A resolution from the Indiana State Medical Society disapproving compulsory attendance at meetings was referred to A.M.A. Delegates for consideration.
11. Doctors Schaaf, Sharp and Evans were appointed on the Committee on General Practitioner Award. They will study all aspects of such award and report back at next meeting.
12. The Trustees approved in principle the

recommendation of Middle Atlantic States Conference that state and county societies activate committees on civilian defense by appointing subcommittees to cover every conceivable major aspect of the problem; and further that the Committee on Emergency Medical Service study the plan of the Philadelphia County Medical Society and pass such information on to county societies so that state and counties have same organizational structure.

13. The Trustees approved the policy that Public Health Week is a Medical Society Project and is sponsored from a medical viewpoint; that participation in Public Health Week is limited to The Medical Society of New Jersey and those organizations which have been officially approved by the Society.

14. The chairman was authorized to appoint a special committee to consider the recommendation of House of Delegates on attendance of delegates at meetings of the House.

15. The secretary was instructed to communicate with Governor Driscoll requesting the opportunity to submit recommendations for appointment of physicians to the Advisory Council on Disability Benefits.

16. The Trustees approved the recommendation that the Subcommittee on Medical Practice promptly get in touch with the Commissioner of the Unemployment Compensation Commission to work out a standardized form for the reporting of illness and recovery under the new Cash Sickness Benefits law.

17. The Trustees approved the project of the Subcommittee on Public Relations to sponsor with the State Department of Education a contest for school essays on the topic "What Are the Essentials of a Good School Health Program?", offering two $50 prizes for the state winners in grammar schools and high schools, the prize money to be allotted from the Committee's budget.

18. The *Statement of Policies* of The Medical Society of New Jersey (see page 354) was approved; the Public Relations Committee was authorized to have 25,000 copies printed in pamphlet form for general distribution, the cost of such printing not to exceed $500; the distribution of the pamphlet to be left in the hands of the Public Relations Committee.

19. Doctors Sica, Allman, Hornberger and Norton were appointed members of the House Committee for 1948-49.

20. The chairman was authorized to appoint special committee to review the audit report for 1947-48.

21. Dr. Joseph E. Mott, Paterson, was appointed member of the Publication Committee to fill the vacancy created by the resignation of Dr. Lewis W. Brown, Newark; and Dr. Ralph M. L. Buchanan, Phillipsburg, was appointed to fill vacancy created by resignation of Dr. J. Lawrence Evans, North Bergen; both appointees to serve until the next annual meeting.

22. The Trustees endorsed the position taken by the A.M.A. opposing selective service bills requiring registration of physicians up to the age of 45, and instructed that action implementing this position be taken by the Society and not through the channels of the Woman's Auxiliary.

DR. BERTHOLD S. POLLAK 1873 - 1948

Seldom is an institution named after a living man. This rare honor, however, was bestowed on Dr. Berthold S. Pollak in 1946 when the Freeholders of Hudson County named their tuberculosis hospital "The B. S. Pollak Hospital for Chest Diseases". This gracious act is a clear testimonial of the standing which Dr. Pollak enjoyed among the leaders of his community.

Dr. Pollak was 75 years old on June 26, 1948. On June 27 he died, bringing to a close a career of professional distinction and public service rarely found in a single personality. By The Medical Society of New Jersey, he will always be remembered as a particularly vigorous and effective chairman of the Subcommittee on Legislation. His day by day work on this subcommittee had meaning to every citizen of New Jersey, for he erected the committee into a bulwark against substandard health legislation. It was a difficult assignment and it required a rare combination of forthrightness and diplomacy, ingenuity and vision. But it was an assignment to Dr. Pollak's liking and he met it superbly.

Born in Vienna in 1873, he came to this country at the age of 15. He first became a pharmacist, later studied medicine, and in 1898 moved to Jersey City. He was one of the first New Jersey practitioners to specialize in diseases of the chest. He organized his county's tuberculosis league, re-organized the county tuberculosis hospital, represented the National Tuberculosis Association at no less than seven foreign conferences. He promoted county wide tuberculosis clinics.

THE MEDICAL SOCIETY OF NEW JERSEY

A STATEMENT OF POLICIES

The Medical Society of New Jersey has accepted leadership in providing a better distribution of a higher grade of medical care to the people of our state.

Certain policies have been evolved over a number of years through the functioning of a democratic organization within The Medical Society of New Jersey. This organization comprises representatives of each county medical society in the state, who meet in a Welfare Committee, with numerous advisory and subcommittees, to consider medical, social and economic phases of health and medical problems as they arise from month to month. When decisions are made in the advisory and subcommittees, after thorough discussion, study, and often public hearings, they are presented to the Welfare Committee as a whole. If approved, they are sent to the Board of Trustees for final approval. Thereafter, they become the official policy of The Medical Society of New Jersey, unless modified by the House of Delegates of the Society in Annual Convention assembled.

Some of these policies are presented herewith for the purpose of securing public cooperation in the efforts of The Medical Society of New Jersey, through its membership of some five thousand component members, to provide the highest grade of medical care for all the people of New Jersey.

THE PHYSICIAN AND THE HOSPITAL

The medical care of patients in all hospitals is the sole responsibility of the attending physician. In the care of a hospitalized patient, the attending physician may call on many services, including consultations, diagnostic and therapeutic help from other physicians, nurses, technicians, pharmacists, and others—but the attending physician is responsible for the patient. He may transfer this responsibility to another physician with the patient's consent.

Hospitals are institutions which make available to physicians, facilities for the care and treatment of patients. They are prohibited by law in the state of New Jersey from practicing medicine in any of its branches.

It is the purpose of The Medical Society of New Jersey to do everything in its power to cooperate with hospitals to achieve better and higher standards of medical practice. However, it will do everything in its power to discourage and prevent the corporate practice of medicine by hospitals, and to bring about the discontinuance of such practice where it exists.

PRIVATE PRACTICE OF MEDICINE

The great majority of physicians in the state of New Jersey are engaged in the private practice of medicine. This system is based on a fee for service plan. It permits each individual to select his own private personal physician and to make his own personal arangements for payment of his own medical services. The health care of each self-supporting individual and his medical care in case of illness is, therefore, his own primary responsibility. The Medical Society of New Jersey, through its membership of 5000 members is pledged to uphold this system of medical practice and will do everything in its power to improve further the standards and quality of medical services rendered by its component members.

DISTRIBUTION OF MEDICAL CARE AND HEALTH SERVICES

For many years The Medical Society of New Jersey, through its special committees, has been evolving and supporting a program, paralleling the advances in scientific medicine, to make adequate medical care and health services available and attainable to every person in New Jersey. The principles of the medical care phase of this program are: (1) that the fees and charges be within the ability of the patient to pay; (2) that it provide for free choice of physician and patient; (3) that payment for such services be on a fee for service basis, or such other basis as is approved by the Society; (4) that no third party interfere with the professional relationship between the patient and physician; and (5) that the program be in accordance with local need and under local control.

MEDICAL CARE OF NEEDY PERSONS

The providing of adequate medical care to needy persons is by law a responsibility of each municipality in New Jersey. State financial aid to each municipality in defraying the cost of such care is available through the Division of Municipal Aid of the New Jersey Department of Economic Welfare. The average contribution by the state to the municipalities is 40 per cent of the cost.

The type of program varies. In large municipalities, office care is usually provided in public clinics and home care either by physicians of the patients' choice or by city physicians. In smaller municipalities both office and home care are provided either by physicians of the patients' choice

or by city physicians. In all municipalities cases admitted to hospitals for care are rendered care without charge by the members of the hospital medical staffs.

Under these programs needy persons are usually considered those persons whose names appear on the relief rolls of the municipalities. The Medical Society of New Jersey advocates: (1) that the term "needy persons" be interpreted to mean all persons, who because of low income, are unable to provide themselves with adequate medical care; (2) that the determination of need be made at a local level by representatives of local government; (3) that all needy persons be allowed free choice of physician except those cared for in public clinics and in hospitals. The Society approves of tax subsidy for the care of needy persons under programs operated in accordance with principles set forth in this document titled "Policies of The Medical Society of New Jersey". Medical Service Administration of New Jersey, a subsidiary of the Society, will be glad to assist in the solution of any problem involving medical care distribution among needy persons.

MEDICAL CARE OF SELF-SUPPORTING PERSONS

The expressed need of self-supporting persons is for financial assistance in defraying the expense of medical care occasioned by serious or catastrophic illness. The Society has taken steps to meet this need by the organization of Medical-Surgical Plan of New Jersey providing medical, surgical, obstetrical, consulting and anesthesia services rendered persons admitted to hospitals for treatment, geared to providing complete payment for services rendered persons with incomes below the income levels specified in the Plan's subscription contracts.

COOPERATION WITH HEALTH AND WELFARE AGENCIES

As a matter of long established policy, The Medical Society of New Jersey, through its members and committees, has always cooperated in the programs of official and non-official health and welfare agencies of the State to develop adequate public health and medical care services to the clients of such agencies. The Society and its members will continue to cooperate with such agencies in accordance with the following principles, as adopted by its House of Delegates, with the subsequent approval of the House of Delegates of the American Medical Association:

1. The Medical Society recognizes the need of supplying the professional and administrative leadership necessary to furnish public health services and adequate medical care, to the people of the state.

2. The Medical Society and the health and welfare agencies should maintain continuing liaison with each other to implement these principles.

3. The Medical Society has appointed the necessary committees to study the public health and medical care problems concerned, and to supervise projects relevant to these problems.

4. The Medical Society pledges itself to maintain a high standard of professional skills among the medical personnel assigned to these projects, and to supervise such activities with a view toward maintaining high scientific standards and preventing personal exploitation.

5. The Medical Society invites and welcomes the active participation in its scientific programs by the qualified medical and non-medical personnel of the appropriate health and welfare agencies.

6. The cooperation of health and welfare agencies will always be welcomed by The Medical Society in the implementation of these projects.

7. On the part of the health and welfare agencies, it is expected that: (1) they will select their part-time medical personnel from lists furnished by, or with the approval of, The Medical Society; (2) they will clear through The Medical Society any grievances concerning medical personnel; (3) they will protect the private practitioner and family doctor by discouraging treatment in preventive clinics, and by returning to the family doctor any cases not economically suitable for examination or care at the health or welfare agency; (4) they will not profit financially by the labors of any medical personnel working in their projects (that is, they will not engage in the corporate practice of medicine); and (5) they will seek the cooperation of dental, nursing and pharmaceutical organizations in a program fashioned to accord with these principles.

The Medical Society recognizes a paramount responsibility to give aid and professional counsel to all groups of citizens who have a sincere purpose to solve, or to contribute to the solution of, problems affecting the health and welfare of the people.

In practice, the special contribution of The Medical Society of New Jersey in these matters has been through the designation of advisory committees to guide the formulation of medical policy, and subsequently, through organized participation in the public service programs evolved by these agencies.

MEDICAL AND PUBLIC EDUCATION

The declared purposes of The Medical Society of New Jersey are, in part, "to advance medical science, elevate professional standards . . . . to educate the public in prevention of disease and the preservation of health; and, in general, to render this profession most capable of serving humanity."

MEDICAL EDUCATION

In cooperation with New Jersey's principal institutions for graduate education, The Medical Society and its component county societies

make available regular courses in post-graduate medical education for the practicing physicians in various areas of the State. The Society also sponsors clinical training programs for general practitioners, with the cooperation of voluntary hospitals.

The annual Spring Convention and the Fall Clinical Conference of The Medical Society of New Jersey comprise an intensive "refresher course" for practicing physicians, not only on general topics but in the various specialized sections sponsored by the Society.

The Medical Society favors establishment as soon as possible of a regular four year class A medical school in New Jersey, believing that such a school will have an enormously helpful influence upon the maintenance and elevation of standards of medical practice throughout the entire State.

PUBLIC EDUCATION

The Medical Society of New Jersey sponsors weekly health educational programs broadcast from ten radio stations in the state, and is extending its work in this field by promoting additional radio programs of educational value.

The Society distributes a weekly health educational column to all the newspapers and industrial house organs in New Jersey. A similar service is provided for more than 1600 schoolroom teachers, in connection with their health educational programs.

The Society sponsors an annual "Public Health Week", through its component county societies, designed to acquaint the public with their local health resources and to increase their understanding of health and medical affairs.

Through its package library service on medical subjects, The Medical Society of New Jersey assists individual physicians in preparing for speaking engagements before lay groups, arranged through the Speakers' Bureaus maintained by the county societies.

The Society participates actively in the health educational programs sponsored by lay organizations in the fields of tuberculosis, diabetes, heart disease, cancer control, venereal disease, crippled children, infantile paralysis, etc.

PUBLIC HEALTH AND PREVENTIVE MEDICINE

The Medical Society of New Jersey supports the American Medical Association's declaration that "preventive medical services should be available to all and should be rendered through professionally competent health departments". We recognize and emphasize four basic requirements for a good public health program: (1) a strong, well-supported State Health Department; (2) adequate local health services provided by a professional staff of full-time health workers, responsible to a sufficient large population unit to support a modern health department; (3) a basically sound health education program; (4) optimum cooperation between the health department and the practicing physician, so that the latter will function as an integral part of all community health work.

The Medical Society also subscribes to the principle enunciated by the American Medical Association that "Minimum standards of nutrition, housing, clothing and recreation are fundamental to good health". We, therefore, support all efforts or proposals within the framework of American democratic principles to assure at least such minimum standards to all the people.

We believe that public health work is most effective when the people, both collectively and as individuals, participate in it. Hence, The Medical Society of New Jersey proposes to take an increasing initiative in organizing county and local public health councils comprising representatives of all agencies interested in public health. These councils will study local health problems, arouse public support for improvement of local health services, and endeavor to persuade the people that health services, both public and private, are first of all the responsibility of the individual, and that personal good health is worthy of at least the same attention and sacrifice as less vital personal services.

The Medical Society of New Jersey holds that good prenatal and maternity care should be available to all mothers, and that all children should have the benefit of scientific nutritional guidance, immunization, health examinations, and corrective services during their entire preadult lives. Such services should, insofar as possible, be obtained through the family physician, but for those unable to pay for these services, they should be available through child health centers, and public medical services, locally administered and controlled.

The Medical Society of New Jersey believes that one of the most urgent needs in the realm of public health is for a coordinated health educational effort by all interested groups and agencies.

LEGISLATIVE POLICIES

The legislative policy of The Medical Society of New Jersey is to concern itself only with measures which are of direct concern to medicine or have public health and medical

implications. Here, because of our training and experience, we can speak with a measure of authority.

One of our major legislative objectives, perhaps the most important one, is the maintenance of high standards for all who seek a license to treat the sick in this state. We oppose all bills which would permit graduates of substandard medical schools to become eligible for examination for licensure to practice medicine and oppose any legislation which would set up a dual standard for measuring the fitness of those who are to be licensed. Medicine, dentistry, nursing and pharmacy, through the Conference of Allied Medical Professions, act unitedly in this major purpose. As influential lay organizations become more acquainted with the objectives of The Medical Society of New Jersey, these organizations are increasingly supporting legislation which we advocate.

The Medical Society of New Jersey initiates and supports affirmative legislation for the improvement of health standards and practices, whenever indicated.

Nationally and at the state level, we oppose bills which may directly or indirectly bring about government control of medicine.

GOVERNMENT CONTROL OF MEDICAL PRACTICE

The Medical Society of New Jersey is firmly opposed to governmental control or operation of medical services, as currently embodied in federal proposals for national compulsory health insurance. Our reasons for opposing this and other forms of "state medicine" are well expressed—and impressively supported—by the Brookings Institution, a world-renowned research organization. In a report released in April 1948 to the U. S. Senate Subcommittee on Health, the Brookings Institution warned against enactment of national compulsory health insurance, asserting that such a system would "necessitate a high degree of governmental regulation and control over personnel and agencies engaged in providing medical care"; second, that it "does not seem probable that politics could be eliminated from medical care supplied under a governmental system"; third, that "real danger" exists that government intervention would impair the relationship of practitioner and patient; fourth, that the administration of such a measure "would require thousands of government employees for accounting, auditing, inspection and investigation"; and, finally, that "the cost of medical care presumably would increase".

We believe that all legitimate objectives of national compulsory health insurance can and will be achieved through voluntary cooperative action with our local communities, counties and states, at less expense, and with greater satisfaction to the patient. We believe the paramount concern of the citizen is to preserve a system of medical practice that will maintain the present high quality of medical service and freedom of choice for the patient. We are convinced that the average American would prefer to be attended by a physician who is responsible to him, rather than by an agent responsible to the government.

CARE OF THE CHRONIC ILL PATIENT

The care of the chronically ill ranks as one of the most important medical problems facing the profession today. A survey has revealed that there are approximately three quarters of a million people in New Jersey partially or wholly disabled by chronic disease or permanent impairments. Chronic disease is no respector of age, color, creed, or sex.

These patients must receive generally the same quality of medical care given to the acutely ill patient, and they can be roughly divided into three groups as far as treatment and care are concerned. The ambulatory who comprise the largest percentage should be cared for in their own or foster homes or in clinics or institutions which can provide domiciliary care. A smaller number require private or public sanitarium care. The third and smallest group require hospital care in general hospitals, or in close relationship to general hospital facilities so that the chronic ill will have the benefit of all the skills and services available to other types of patients.

Many patients suffering from chronic disease with more adequate diagnosis and medical care can be rehabilitated and returned as useful members of society, and it is a partial responsibility of the profession to see that more adequate provisions and skills are made available in the future. This involves many factors of a social and economic nature.

CONCLUSION

These policies demonstrate the leadership The Medical Society of New Jersey has taken in solving our present day problems of wider distribution of medical care and new forms of payment for medical services.

It has been the purpose and aim of The Medical Society to preserve all the best traditions of medicine, but at the same time, to evolve new plans of distribution of medical services, which will make available to all the people the highest type of medical care.

The Medical Society of New Jersey, as a component member of the American Medical Association, is united in the determination to preserve our free system of medical practice which has resulted in the highest type of medi-

cal care available anywhere in the world. Changes in medical practice have been constant; new methods of diagnosis, treatment and preventive medicine have developed from year to year. Organized medicine has a background of achievements in public service and scientific accomplishments which we are proud of. We look forward to the future with confidence, and welcome the support and cooperation of the public in achieving these aims.

CONFERENCE ON MEDICAL SERVICE

This is a report of the sixth semi-annual Middle Atlantic States Regional Conference on Medical Service held in Philadelphia on May 13, 1948. Attending on behalf of The Medical Society of New Jersey were Dr. Hornberger, Dr. Quigley and Mr. Bryan. This abstract was prepared by Mr. Bryan.

Feature of the morning session was a discussion of: "Developing team play between Blue Cross and Medical Service Plans". The luncheon session was addressed by Dr. Edward L. Bortz, president of the A.M.A.; and the afternoon was devoted to national emergency medical service, the Washington legislative situation, and organized medicine's responsibility in the development of county health units.

In his introductory remarks, Dr. Francis F. Borzell, chairman of the Conference and vice-speaker of the A.M.A. House of Delegates, emphasized the importance of state societies attempting to put their programs into effect at the local level by cooperative action through the county medical societies.

Discussion of team play between Blue Cross and medical service plans was opened by Dr. L. Howard Schriver of Cincinnati, president of The Associated Medical Care Plans. He described the developments leading to the employment of Dr. Hawley as coordinator of Blue-Cross and Blue-Shield programs. He reported that at a recent meeting of the Blue-Shield (medical) plans, it had been decided to reject the proposal for a merger of Blue-Cross and Blue-Shield and for setting up a national insurance plan. (Note—parallel action has recently been taken by our own House of Delegates on these two points.)

Instead a joint committee representing Blue-Cross and Blue-Shield has been set up to draw plans for an association, not a merger, the purposes being to serve local plans, to assist in their public relations work, but by no means to disturb the autonomy of local plans or to destroy their existing structures. The organizational layout for this association is to be drafted and submitted to the commissions of A.M.C.P. and Blue-Cross. It is proposed that the Board of Governors of this new association be composed of one representative each from the medical and hospital groups in each of the twelve national districts, plus four representatives of the American Hospital Association, and four representatives of the A.M.A. There would be a strong executive committee, comprising Dr. Hawley and the officers of the association to be elected by the governing board.

One function of this new organization will be to work with existing local plans to make certain that all areas are covered throughout the country.

Discussion of the topic was continued by Mr. E. A. Van Steenwyk, executive director of the Associated Hospital Service of Philadelphia, who said that the major problem now is to get high enrollment. He pleaded for development of "a mood in our mechandising" which will emphasize that the two groups have similar purposes. He feels that the plans should be presented to the public as being together, that they should profit by each other's public acceptance. He emphasized that the "team" comprises not only the Blue-Cross and Blue-Shield Plans but also cooperative health plans, farm group plans, industrial programs, and even commercial insurance company policies. He pointed out that all these groups favor voluntary rather than compulsory health insurance, and therefore, though they do not agree always with each other, they are all "playing on the same team".

There was considerable discussion of whether hospital plans are promoting the practice of medicine by hospitals in writing into their policies coverage for diagnostic services (x-ray, pathology, anesthesiology, physical therapy, etc.). A comprehensive study of hospital practice of medicine is being conducted by an A.M.A. committee under the chairmanship of Dr. Elmer Hess, president of the Pennsylvania State Society, who was present at this meeting.

Dr. Erval R. Coffey, medical director of the U.S.P.H.S., pointed out that the medical profession is judged by the public not just by what doctors say and do but by all health and hospital services; and he concluded that the medical profession has a right to be interested in the

policies, standards of service and accomplishments of hospitals, health departments, and all medical agencies. The public, he said, blames the medical profession when things go wrong in any of these auxiliary services.

Mr. Rufus Rorem, former director of the Blue-Cross Commission of the American Hospital Association, pointed out that the layman is always concerned with the quality of services. The lay public is extremely tolerant of professional leadership; it will accept such leadership even if it does not believe it is entirely right, but the public is intolerant of a lack of leadership on the part of the profession. Dr. Chadwick of Pennsylvania said that medicine is in the unique position of being required not only to provide its product but also to provide mechanisms to help the public to buy that product.

Dr. James A. Sargent, chairman of the A.M.A. Council on National Emergency Medical Services opened the afternoon session with a plea to all county and state societies to activate civilian defense committees, and, with each other, to coordinate plans for relief of civilian population in the event of a military disaster on the home front. In this connection, a spokesman reported the action of the Philadelphia County Medical Society which has organized such a committee and has set up six subcommittees covering every major aspect of the problem. Members of the conference were so impressed by the Philadelphia plan that it was decided that copies of this be sent to all state and county societies in the area, in the belief that this work can best be coordinated over the Middle Atlantic States as a whole if all the state and county societies are set up along the same organizational plan.

Dr. Sargent discussed the stand taken by the A.M.A. in opposing the proposed drafting of physicians up to the age of 45, stressing that the A.M.A. is convinced that such action is unnecessary, discriminatory, and dangerous, particularly in peace time.

Dr. Joseph S. Lawrence, director of the Washington office of A.M.A., spoke on the federal legislative situation. S.140, to create a department of health education and welfare, he said, is unlikely to get on the calendar in the present session. The bill to authorize American participation in the World Health Organization is likely to be unfrozen in the House of Representatives and will shortly be passed overwhelmingly. National health bills are unlikely to be reported at this session. Radical reductions in the appropriations for the Security Agency, particularly for the office headed by Mr. Falk, are considered likely to reduce their activities to a noticeable extent.

Dr. Lawrence said that the public (including labor unions) arebeginning to acknowledge the importance of quality in medical care and to concede that there is a greater likelihood of getting good medical service by voluntary methods than by compulsory health insurance. He said this growing conviction accounted, at least in part, for the failure of the National Health Assembly to indorse national compulsory health insurance.

Dr. Lawrence emphasized his own belief that the most urgent, dangerous, and difficult problem facing organized medicine is financing voluntary hospitals and keeping them alive as such. He suggested, the decentralization of hospitals, the provision of more diagnostic services, more convalescent and nursing homes.

Dr. P. F. Lucchesi, chairman of the Council on Public Health of the Medical Society of the State of Pennsylvania, cited the resolutions which have been adopted by the A.M.A. and by various state societies in support of county health departments, but expressed the opinion that there has been no perceptible follow-up action at the state society level. Dr. Lucchesi also made a plea for the establishment of a section on public health in every state society in order to encourage and promote the professional spirit among health officers.

ADVANCE ORDERS FOR TRISTATE DIRECTORY

Now is the time to put in your advance order for the 1949 edition of the Medical Directory of New York, New Jersey and Connecticut. This valuable volume names every practitioner in the three states, gives his medical school, specialty and hospital connections, and lists every hospital in the area with full staff rosters. The cost of this compendium is fifteen dollars. Because of the paper shortage, only enough copies will be printed to meet the demand. While it will not be ready for distribution until January 1949, you must order it this summer if you want to be sure of getting your copy. Send the check for $15 and your order to Mr. Dwight Anderson, Medical Society of New York, at 292 Madison Avenue, New York 17, N. Y.

E. J. ILL AWARD TO DR. SCHAAF

On May 20, 1948, the E. J. Ill Award was presented to Dr. Royal A. Schaaf, junior past-president of The Medical Society of New Jersey. Dr. Schaaf was the tenth recipient of this covetted award, bestowed when merited for distinction in the joint fields of medicine and citizenship. In presenting the award, Dr. Clymont MacArthur, president of the Academy of Medicine of Northern New Jersey, said:

My friendship and professional acquaintance with Dr. Schaaf now cover a quarter of a century and each year has but served to reaffirm the picture of a physician devoting his life to his patients and



Clymont MacArthur, M.D., Arthur Vanderbilt, Chief-Justice Designate of New Jersey, and Royal A. Schaaf, M.D.

his profession. His greatest joy is his work. With a practice that would stampede most of us, he is never too rushed to sit down with us; to stop in the hospital halls, or answer a telephone query to help us over some diagnostic problem, therapeutic procedure or surgical approach. His favorite query of "what's on your mind" is the open sesame to unload your troubles. His unassuming modesty makes us all humble, while his diagnostic acumen at times leaves us breathless. He is ever thoughtful of the other man's feelings, but insistent upon professional integrity. I have yet to see him try to shift the blame when things went wrong or become angry even in situations which were entirely out of his control. His kindliness to the younger men is a by-word and, I am sure, that the hours which he has spent guiding them through some difficult surgical procedure would total an unbelievable number.

But incredible as it is, this is only one part of his busy life. It is not enough that he must help us with our immediate problems but, due to his splendid administrative ability and executive capacity, he has been called upon to serve in all the offices of organized medicine in this state. He has been president of this Academy, president of the Essex County Medical Society and he has just finished his term of office as president of The Medical Society of New Jersey. At this time he is president of the State Board of Medical Examiners and Society of Surgeons of N. J. Each office has gained prestige through his occupancy. Each one of these positions has been demanding of his time, of which a physician has so little, and he has given it unqualifiedly and unselfishly. To us men who have profited, directly or indirectly, by these services of Dr. Schaaf, the admonition "Go Ye forth and do likewise" surely holds.

Royal—on behalf of the Council and Members of



the Academy of Medicine, it is my happy privilege to present to you this award and with it, our deepest admiration and affection.

Another distinguished speaker at the meeting, was Arthur Vanderbilt, Chief Justice designate of the state of New Jersey. Justice Vanderbilt made the point that physicians should accept their obligations as "natural leaders" to promote good government. Declaring himself "a friend and patient of Dr. Schaaf's" the Chief Justice designate pointed out how Dr. Schaaf demonstrated in his life and work the role a physician should play in his profession and government. If democracy is to survive, he said, it needs the time and thought of "the natural leaders of the community—the leaders of the professions, of business and of labor". He conceded that most doctors haven't time to seek or hold public office.

"I have a feeling we professional men, generally speaking, are rather poor citizens," He declared every professional man has the obligation to be intelligent and informed about public

affairs, vote intelligently and honestly, and encourage everyone who is trying to do a good job in public office.

On the last point he added:

"I can say from 28 years' experience—which is a phase I'm all through with now—that for those in public life the knocks outnumber the kind words 100 to 1."

For the first time since its foundation in 1911, keys were awarded past presidents of the academy. Dr. MacArthur presented them to the 12 of the 22 presidents who preceded him who are living. Dr. Earl LeRoy Wood, incoming president, made the presentation to Dr. MacArthur. Others who received keys are:

Dr. Harrison S. Martland, Dr. Harry B. Epstein, Dr. E. Zeh Hawkes, Dr. Ervin Reissman, Dr. Max Danzis, Dr. Henry C. Barkhorn, Dr. Charles M. Robbins, Dr. Edward W. Sprague, Dr. John W. Gray, Dr. Schaaf, Dr. Lee W. Hughes and Dr. Joseph I. Echikson.

In response, Dr. Schaaf said:

I am deeply grateful to the officers, trustees and members of the Academy of Medicine of Northern New Jersey, for the signal honor which they have conferred upon me by designating me to be the recipient of the Edward J. Ill Award for 1948. My pleasure and gratification upon receiving the award are in no wit diminished by my acute consciousness of the fact that the recognition being accorded me is out of all proportion to my actual professional attainments or my contribution to the welfare of my fellow physicians and the people of New Jersey. I feel that, rather than being honored myself, I should be expressing my appreciation to the members of the various medical and lay organizations of which I have been a member or an officer, for the opportunities which they have given me to participate in, and upon occasion, to direct, activities which interested me immensely and from which I derived great pleasure. I have, in fact, only two major interests in life aside from my family—viz.—the active practice of medicine and the work of medical, health and welfare organizations. If in the course of playing a game which I have enjoyed enormously, I have contributed something to my profession or to our people, I am very happy.

In response to the citation accompanying the Edward J. Ill Award, the selection of the title is the privilege of the recipient. Instead of delivering a pseudo-philosophical discourse or an essay on the current problems concerning our profession in the medical, social, economic or political fields, I have elected to discuss the need for an approved medical school in New Jersey. Since this Academy is exclusively a medical educational organization, the presentation of this subject here seems to me to be especially appropriate.

An approved modern medical school is not merely an institution for the teaching of students of medicine. Directly or indirectly, such a school also elevates the existing standards of medical practice, graduate medical education and public health, not only in the community in which it is situated, but also in a large surrounding area, the benefits often reaching quite remote parts of the state. The many advantages of a first class medical school are readily apparent and are too well recognized to require extensive comment. New Jersey, through our State University at Rutgers, now provides state collegiate education in practically all branches of learning except medicine and dentistry. Many states with much smaller population than ours, and with fewer and less adequate clinical facilities, have provided excellent medical schools as part of their universities.

With no medical school in New Jersey, our prospective students of medicine are obliged to seek an education in colleges in other states. Most of them matriculate in medical colleges in New York state or Pennsylvania, but not a few finally are accepted by schools as far away as the Pacific coast. Although the number of students in New Jersey accepted by schools elsewhere seems to be quite fairly apportioned, nevertheless our students are at a distinct disadvantage in some respects.

At the present time, with at least ten applicants for each available place in a medical school, a great many well qualified candidates must forego their life's ambition and enter some other field of endeavor for which they have little aptitudes and less enthusiasm.

Unless existing facilities for medical education are augmented or additional ones provided, it is almost certain that by 1960 there will be a marked shortage of physicians to meet the demands not only of private practice but also of public health, military, veterans administration and other organized medical groups.

With a population of 4,500,000 people and with many well equipped and high grade hospitals to provide almost unlimited clinical facilities, New Jersey would be an ideal area in which to establish one of the needed new medical colleges.

Although there are now in the United States four or five approved medical schools conducted as independent units, it is certain that no new medical schools will be developed except under university auspices. A medical school is the most expensive unit of any university. None of them balance their budgets with current revenues from tuition. All operate with deficits which are made up either by income from endowments or direct contributions from general university funds. Rutgers University is now undertaking a great expansion of existing facilities for which some thirteen million dollars will be expended within the next three years. The long term program contemplates expenditures up to fifty million dollars. Now is the time for the medical profession of New Jersey to bring to the attention of the Governor, the Legislature and the authorities of Rutgers, the urgent need for the inclusion of an approved medical school in the contemplated projects. Questions regarding the cost of construction of the required physical plant and the cost of maintenance will immediately arise and

we must be ready with the answers. The cost of maintenance can be estimated with fair accuracy at $500,000 a year. Part of this would be met by tuition fees; the balance, by legislative appropriation. The cost of the plant structure would be considerable — perhaps $10,000,000 — which would include the school building with its laboratories and class rooms, the dormitory and the University Hospital, the three indispensable units of a medical center.

This is a most opportune time to undertake the establishment of a medical school in New Jersey. With the new thousand bed hospital being constructed by the Veterans Administration in Newark, and with the new thousand bed City Hospital soon to be erected in Newark, with which the University Hospital could be built and integrated, an adequate medical center could be constructed at the lowest cost. If the medical center were established in Newark, it would have not only the resources of the Veterans Hospital, the new Newark City Hospital and its own University Hospital, but also it would be close enough to Jersey City so that the excellent clinical facilities now existing in Jersey City Medical Center could be utilized effectively.

The Board of Trustees and the House of Delegates of The Medical Society of New Jersey have already endorsed the principle of "an approved medical school under University auspices supported by appropriations from general tax funds" and have notified the Governor and the officials of Rutgers and Princeton Universities of that fact.

At our recent Annual Meeting, the House of Delegates approved a resolution calling for the appointment of a committee of sixteen members, four from the University of Rutgers, four from The Medical Society of New Jersey and eight to be appointed by the Governor from interested lay people. The function of this committee would be to study the need for, the cost of and the practicability of the establishment of a medical school in New Jersey. Upon completion of its study, the committee would submit its report and recommendations to the Governor for his consideration and, we hope, his endorsement.

In conclusion may I say that in my opinion, we need a medical school in New Jersey. Its establishment in the near future is practicable and that with coordinated effort the project can be brought to a successful conclusion within the next few years to the great benefit of the people of the state by the consequent elevation in the standards of undergraduate and graduate medical education, medical practice and public health.

MEDICAL CARE FOR STATE CLIENTS

(This is a report made by Dr. Scott on medical care for clients of the Old Age Assistance Division and for wards of the State Board of Child Welfare. The report was presented to the Welfare Committee on May 23, 1948.)

The medical care of Old Age Assistance clients and clients of the State Board of Child Welfare were problems referred to Medical Service Administration during the winter. We reported back to the Trustees with recommendations which were approved and referred to the county societies.

Old Age Assistance clients have been cared for rather unsatisfactorily from the standpoint of the Old Age Assistance Division and from the standpoint of doctors for the reason that the Division cannot directly pay the physicians for services rendered clients. These are payable from federal funds and federal funds cannot be expended directly to a vendor. The physician is considered a vendor of medical care. This money must be paid directly to the client. This is handled in two ways: (1) In most counties, a health survey of each client is conducted to determine necessary medical care. The amount required to pay for this care is added to the client's allowance each month. This grant is made whether or not the client pays the doctor. Of course, the doctor doesn't often collect; the client is likely to spend it on some other necessity. (2) Another method is for the doctor to bill Old Age Assistance each month for services rendered and then that specific amount is added to the client's allotment.

In accordance with principles agreed upon previously, there will be a review committee in each county society for questionable cases. Patients are to have free choice of physician for the first visit during any one month. Subsequent visits for the month are to be authorized by the county welfare board in accordance with a procedure approved by the county medical society. Physicians will bill the welfare organization of the county each month for services rendered each of their clients. So that these bills be recognized and the amount added to the client's allotment, a notice is prepared to the effect that so many dollars has been added to the check to cover the expenses of Dr. So-and-So. It is up to the client to pay and the doctor to collect. We think this will satisfy the requirements of clients and doctors. The fee will be $2 for an office visit and $3 for a house visit within city limits or within five miles of the nearest available physician's office. If the distance is over five miles, the fee is $4. Services rendered multiple eligible persons during same visit will be full fee for one person and half fee for each additional

eligible person, with a ceiling of $6 for any one visit. The limit is $25 per month for any client unless approval is received through the advisory committee.

This program has now reached the stage where it must be referred to the county societies for inplementation. It is a policy of The Medical Society of New Jersey which should be inplemented on a county level.

Another group to be considered is the Board of Child Welfare. They have 24,000 children and mothers dependent on them for medical care. Federal funds are involved, but they are all expended for rent, food, clothing, etc., and do not cover medical care. These patients, or their mothers or guardians, are given a definite allowance for each child each month. This budget does *not* include medical care. These bills are to be sent directly to the district office of the Board of Child Welfare. Prior to this, these children and the mothers had been cared for by a "selected physician". They want to provide for free choice of physicians from among a list of physicians willing to participate. This list will be presented by the county society. They expect to provide payment for physicians' services on a fee-for-service basis. If the physician meets the requirements and is willing to work for the established fees he can be chosen as physician for that family. He will bill the office in his county and be paid directly by the office. The fee schedule is $2 for office calls, $3 for home visits. A committee within the county society will pass on controversial matters. This must also go before the counties for implementation.

NORMAN M. SCOTT, M.D.

DISCUSSION

MR. JAMES E. BRYAN: Mr. Dowdell of the Assistance Division reports that they intend to promulgate an administrative regulation embodying principles which will be agreed upon with the medical societies and make that regulation finally effective on November 1 of this year. Therefore, between now and November all of his district supervisors will be required to consult with the appropriate county medical society and come to agreement upon a plan that will be in line with the principle agreed upon with us.

DR. COLLINS: I wrote to our district office, about the fees. They said they are now $1.50 and $2.50, and seemed to know nothing of the new agreement.

DR. SCOTT: They will be $2 and $3. Mr. Dowdell has not made the matter known in the counties because he felt that this should first go through the county medical societies.

MR. BRYAN: There is no reason why the county societies should not immediately take the initiative in consulting with county boards and supervisors.

Mr. Dowdell informed me that the organizations in Washington which dispense federal funds for these purposes have come to the conclusion that this indirect payment for medical services is not a successful way to do business. They are about to sponsor an amendment which would enable direct payment to be the custom from that time. They recognize the present system of payment should be changed.

DR. SCOTT: It is the fees of Old Age Assistance Clients that must be paid through the client at present. Board of Child Welfare clients fees are payable directly. The principles that Mr. Dowdell agreed upon were free choice of physician, payment of services on a fee for service basis with a consulting committee from each county society to decide upon controversial matters. When these children need hospital care, they are hospitalized in voluntary and city hospitals as indigent patients. In Essex County they spent last year $60,000 for what they call medical care. I was going to take it over and operate it through Medical-Surgical Plan, but at a subsequent meeting the breakdown was $24,000 for hospital care, $30,000 for dental care and only $6000 for actual medical care. Most of their expenses are not for home and office calls. And they do not pay for hospitals.

DR. FIELD: In reference to these Child Welfare payments, while they have a fee schedule arranged as in the old age assistance, there are a great many people in rural districts who are not within five miles of the doctor's office. It would be a hardship to drive this distance for $3. I appreciate the fact that the compensation for old age assistance is paid from federal funds, but there is one thing that has been overlooked. You may furnish us with a patient about the middle of a month and about the first of the next month make out this bill. You then have to take the bill to the patient and have him sign it and then go after payment. Thus there are three trips involved.

DR. SCOTT: The Board of Child Welfare has the same basic fee schedule as the Old Age Assistance, but they would pay $4 if the case is more than five miles from the physician's office. Old Age Assistance would not agree with that. They cited their experiences in Warren and Sussex Counties where this question had been raised previously. Mr. Dowdell went to speak at meetings of those two societies and it seems that there had been only one questionable case in the past six months. The societies agreed that if the prevalence of long distance calls was no more than that, the fee was a fair one. As to the other question on the complicated way of collecting fees, this new plan will try to obviate that. The money must go to the patient. There will be a notice sent to the patient that he owes this money to Dr. Jones. Whether the money will be forwarded to the doctor remains to be seen. I think I would insist also, if I were one of the physicians, that I be notified that the payment had been sent to the patient, so I would know the client has received the money.

DR. NITTOLI: Cannot two separate checks be sent to the client, one for his regular allowance and the other for payment to the doctor?

DR. SCOTT: I do not think that suggestion could be worked out because of the additional administrative costs involved.

DR. KRECHMER: I am one of the participating physicians for the Board of Child Welfare in Atlantic County and understand that there is just one other participating doctor in Atlantic City. Here I have bills that I have sent in for payment. I never received any word at all. I keep sending them in and nothing is done about them. I have bills that have not been paid for 1942 and 1943 and they have been submitted month after month.

DR. SCOTT: I am sure as far as Mr. Alloway is concerned, it is his aim that these bills be paid promptly. I will be glad to speak to Mr. Alloway about that.

SUPPLEMENTARY LIST No. 3
TO THE
1948 OFFICIAL LIST OF MEMBERS

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Ambrose, Francis A., 445 15th Avenue, Paterson(16)
Bauch, Solomon, 564 Hawthorne av., Newark (7)
Becker, Meyer, 219 Amboy av., Metuchen (12)
Bristol, Frank E., Main st., Dayton (12)
Brown, Milton W., 72 Roosevelt av., Carteret (12)
Casagrande, Stephen R., 56 W. River rd.,Rums'n(13)
Crane, Warren E., 11 Aberfeldy dr., Trenton (11)
DeVivo, John A., 188 S. 6th st., Newark (7)
Duckett, Warren J., 21 Carlton av., Jersey City (9)
Feldman, Joel, 64 W. Front st., Red Bank (13)
Gilman, Charles M. B., R.F.D., Box 327B, R. Bank(7)
Graham, Richard B., 720 Boston Blvd., Sea Girt (13)
Harman, Wm. J., 740 W. State st., Trenton (11)
Irving, Henry C., 27 Warner av., Jersey City (9)
Katzenbach, C. Buckman, 415 W. State st.,Tr'nt'n(11)
Kerns, Francis J., 526 W. Market st., Newark (7)
Loizeaux, Theodore, 212 E. 7th st., Plainfield (20)
Lomax, Charles L., 417 W. Broad st., Westfield (20)
Lurie, Sol I., 21 Hillside av., Newark (7)
Manahan, Daniel V., 55 E. Front st., Red Bank (13)
Mazzei, Armando. 282 Liberty st., Long Branch (13)
Mineur, Henry J., 117 Alden st., Cranford (20)
Movelle, John B., 840 River rd., Fair Haven (13)
Neiderhoffer, Sydney L., 469 Broadw'y,L.Branch(13)
Niemtzow, Frank, 55 E. Main st., Freehold (13)
Noto, Philip, 158 Washington pl., Passaic (16)
Opfermann, John L., 167 Bay av., Highlands (13)
Ricciardelli, Emmanuel F., 1670 Boulevard, J. City(9)
Robie, Theodore R., 144 Harrison st., E. Orange (7)
Rommer, J. Jay, 25 Ingraham pl., Newark (7)
Rubin, Harold, 601 Grand av., Asbury Park (13)
Santor, G. Frank, 3176 Westfield av., Camden (4)
Schulman, Abraham S., 4518 Boulevard, Union C. (9)
Sena, Dominic R., University Hosp., Coral G.,Fla.(20)
Trippe, Clarence M., 702 Asbury av., Asbury P. (13)
Walsh, Thomas J., Barnes Hospital, Vancouver, Washington (11)
Wittenborn, Wm. F., 1635 Brunswick av.,Trent'n(11)
Zelner, Eugene J., 517 Broadway, Paterson (16)

ASSOCIATES

Dreizin, David H., 201 Lyons av., Newark (7)
Kelly, John L., 82 Clinton av., Newark (7)
Mann, Hillard, 431 Washington av., Belleville (7)
Nelson, Richard A., 763 Broad st., Newark (7)
Silver, Albert M., 89 Lincoln Park, Newark (7)

INDIVIDUAL ARMY SYPHILIS RECORDS NOW AVAILABLE

Dr. Paul Magnuson, Chief Medical Director of the Veterans Administration, has authorized the following announcement, indicating the availability to private practitioners of the syphilis records of individual ex-army personnel. Please note the conditions under which this information will be placed at the disposal of the doctor.

"The Veterans Administration has in its custody most of the syphilis records of those Army personnel who were treated for this disease while in service, and in many instances can procure informative data from the syphilis records of other than Army personnel. Many physicians treating veterans for syphilis as private patients will find a resume of the syphilis record useful since the details of treatment, results of spinal fluid examinations, and blood serologies are incorporated in the records.

"Summaries of these records are available to physicians treating such veterans provided authorization for the release of the data is given by the veteran. Requests accompanied by an authorization from the veteran for the data, (dated and signed by the veteran) should be addressed to the Dermatology Section, Veterans Administration, Munitions Building, Washington 25, D. C. It is important that the veteran's serial number and other identifying information, (such as the date of enlistment, the date of discharge, rank, and organization) be included.

"Ordinarily, the abstracts can be furnished in about two weeks from the date of the receipt of the request and signed authorization".

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

DR. BERGSMA APPOINTED STATE HEALTH COMMISSIONER

Daniel Bergsma, M.D., M.P.H., veteran public health administrator was sworn in June 1, 1948, as New Jersey's first Commissioner of Health under Chapter 177, (P. L. 1947) which reorganized the State Department of Health. He is the first state department head to be named by Governor Driscoll under the new constitution.

Joining the Department in 1938 as a Medical Assistant, he served as Chief, Bureau of Venereal Disease Control from 1940 until he joined the Army Medical Corps in 1942. On his return from service, he was appointed Deputy Director of the Department of Health and served in this capacity until the reorganization law became effective July 1, 1947, when he was named Public Health Consultant.

A native Jerseyman, Dr. Bergsma was born April 4, 1909, at Wallington, Bergen County. He was graduated from Oberlin College, A.B., 1932; Yale University School of Medicine, M.D., 1936; University of Michigan, M.P.H., 1946. He is a Fellow of the American Medical Association and the American Public Health Association and is a member of the American Society of Public Administrators and the American Association for the Advancement of Science. He is Vice-President of the New Jersey Health and Sanitary Association and member of the Advisory Council of the New Jersey Citizens' Conference and of the New Jersey Health Officers' Association.

Dr. Bergsma served a rotating interneship at Orange Memorial Hospital; was Clinical Assistant in Medicine, Yale School of Medicine; and Assistant Resident at William Wirt Winchester Hospital, West Haven, Conn. Joining the Medical Corps in 1942 with the rank of captain, he attained his majority in 1943, was made a lieutenant colonel in 1944, and promoted to colonel in 1946. He was awarded the Legion of Merit, Headquarters Carribean Defense Command.

MINERAL OIL IN FOODS

During World War II as a result of the shortage of edible fats and oils, mineral oil was recommended for cooking a variety of foods such as potato chips, doughnuts, and popcorn. Such products cannot be distinguished from their counterparts made with edible oils except by special laboratory tests. They do not become rancid and may be kept for long periods without refrigeration. Considering these qualities along with claims for such features as "non-fattening" or "slenderizing", it is easy to see how they may be extensively promoted by untrained persons with definite detriment to the public health.

The Food and Drug Administration in 1946 issued this statement:

"Mineral oil is without food value. Its substitution for food oils in common foods has always been regarded as an adulteration under any form of labeling. Under these circumstances the Administration has no alternative but to inform you that mineral oil salad dressings must be regarded as adulterated under any form of labeling. It will be our purpose to investigate such traffic and refer the facts so obtained to the Department of Justice for legal action."

In the Federal Register, March 18, 1948, Food and Drug Administration published the following statements of general policy or interpretation:

"In the past few years research studies have altered medical opinion as to the usefulness of mineral oil in the human body. These studies have indicated that when mineral oil is used orally near mealtime it interferes with absorption from the digestive tract of provitamin A and the fat-soluble vitamins A, D, and K, and consequently interferes with the utilization of calcium and phosphorus, with the result that the user is left liable to deficiency diseases. When so used in pregnancy it predisposes to hemorrhagic disease of the newborn.

"There is accumulated evidence that the indiscriminate administration of mineral oil to infants may be followed by aspiration of the mineral oil and subsequent lipoid pneumonia.

"In view of these facts, the Federal Security Agency will regard as misbranded a drug for oral administration consisting in whole or in part of mineral oil, the labeling of which encourages its

use in pregnancy or indicates or implies that such drug is for administration to infants.

"The act requires the labelings of such drugs to bear a warning against consumption other than at bedtime and against administration to infants. The following form of warning is suggested: *Caution: To be taken only at bedtime. Do not use at any other time or administer to infants, except upon the advice of a physician.*

"This statement of interpretation does not in any way exempt mineral oil or preparations containing mineral oil from complying in all other respects with the requirements of the Federal Food, Drug and Cosmetic Act."

OBITUARIES

DR. HARRY H. BOWLES

Dr. Harry H. Bowles, chief of staff and chief surgeon of Overlook Hospital, Summit, died suddenly of a heart attack at his home in Summit on May 29, 1948, at the age of 64.

Dr. Bowles was born in Millwood, Va., and was a graduate of the University School of Medicine in Richmond. He also studied at Cornell University and in London. Before coming to Overlook Hospital twenty years ago, he was with the Manhattan, Bellevue and Women's Hospitals in New York City.

Dr. Bowles was a fellow of the American College of Surgeons and a member of the Southern Society of New York. He served as a captain in World War I.

DR. LAWRENCE B. BOYLAN

Dr. Lawrence B. Boylan, former county physician, died of a heart attack on June 5, 1948, at his home in Paterson.

Dr. Boylan was born in Newark in 1889, and moved to Paterson at the age of four. He was graduated in 1915 from the University of Maryland Medical School, and interned in St. Mary's Hospital, Hoboken. Later he did special work in tuberculosis at St. Anthony Hospital, Woodhaven, L. I., and Ellis Island. He was a veteran of World War I in which he specialized in heart and lung cases.

Dr. Boylan was a member of the staff of St. Joseph's Hospital and Paterson General Hospital.

DR. HENRY A. COTTON, JR.

One of the state's most promising careers in psychiatry was abruptly terminated on the first day of summer with the death of Dr. Henry A. Cotton, Jr. Though only 40 years old he had risen rapidly within his chosen specialty and was Deputy Commissioner of the State Department of Institutions and Agencies at the time of his death.

He was a graduate of Princeton University and Johns Hopkins Medical School. He joined the staff of the Phipps Clinic in Baltimore in 1935, and the following year became resident psychiatrist at the Jersey City Medical Center. In 1937 he entered the service of the State of New Jersey, first as a resident at the Trenton State Hospital, subsequently as director of the mental hygiene clinics of that hospital.

In 1940 he went on active duty with the Army and rose from the rank of captain to that of colonel. He served first as psychiatrist to the Tilton General Hospital, then as executive officer of the Mason General Hospital, the Army's largest psychiatric installation. In the summer of 1945 he was transferred to Tokyo as psychiatrist on General MacArthur's staff.

On return to civilian practice he was named Deputy Commissioner of the Department of Institutions and Agencies. He became chairman of the advisory committee on mental hygiene of The Medical Society of New Jersey and was elected to Fellowship in the American Psychiatric Association. He was the first chairman of the section on neuropsychiatry of The Medical Society of New Jersey.

See page 353 for obituary on Dr. Pollak.

DR. ALFRED CORNWELL

Dr. Alfred Cornwell, noted as a stomach specialist, died at his home in Bridgeton on May 28, 1948.

Dr. Cornwell was born in Bridgeton in 1870 and was a graduate of Jefferson Medical College. He returned to Bridgeton after serving a year's internship in Philadelphia.

Dr. Cornwell was an honorary member of the Cumberland County Medical Society.

DR. JACOB REINER

Dr. Jacob Reiner, ear, nose and throat specialist of Elizabeth, died suddenly of a heart attack on May 9, 1948.

Dr. Reiner, who was born in New York in 1887, interned at Elizabeth General Hospital following his graduation from Bellevue Medical College in 1908. He was vice-president of the medical staff and a member of the Clinical Society of Elizabeth General, a member of the Society of Surgeons of New Jersey and a fellow of the American College of Surgeons. A veteran of World War I, he served as examining physician in World War II and assisted the late Dr. Charles Schlichter in the Procurement and Assignment Service for Physicians.

DR. DARE WOODRUFF

Dr. Dare Woodruff, well-known Vineland physician and surgeon, died on March 10, 1948, of a heart attack.

Born in Elmer in 1882, Dr. Woodruff graduated from Denver and Gross College of Medicine in 1907, and had practiced in Vineland since 1926. He was a past president of the Cumberland County Medical Society, a Fellow of the College of Physicians and Surgeons, and was on the staff of Newcomb Hospital, Vineland, and the Bridgeton Hospital.

THE BULLETIN BOARD

Doctors and their lay friends who have taken part in debates on socialized medicine frequently remark that the average layman seems to be little, if any, interested in the question of the quality of the medical care he now receives and the inevitable effects of government interference upon the quality of the care he might receive under a federalized system. This observer has often wondered whether his brilliant and compelling arguments against compulsory medical systems on this aspect of quality were really influencing people and making votes for our side. Too often it seems that most lay people are concerned only with quantitative arguments. They assume that if the federal government can double the number of doctors' calls made upon the average citizen each year, he will be twice as well off.

Public indifference to the quality of medical service was strongly disputed recently by Mr. Rufus Rorem, former director of the Blue Cross Commission of the American Hospital Association, who said that the layman is always concerned with the quality of services he receives or is to receive because he either experiences good quality service or lacks it. The question remains, however, whether the patient is always able to differentiate between good and poor quality.

Certainly Mr. Rorem is right in implying that the layman *should be* concerned with the quality of medical service and perhaps it should not be such a difficult matter after all to convince the prospective patient that he is interested in this aspect of the matter.

We have a distinct feeling that over the course of time, and more especially in the last few years, the reasoning of the medical profession on this facet of the question of socialized medicine is really beginning to penetrate the public consciousness. More and more people are actually stopping to ask questions about the quality of medical care and the factors that stimulate high quality or may destroy it.

This impression was supported at a recent conference by Dr. Joseph S. Lawrence, Washington Representative of the A.M.A., who said that the public, even labor unions, are beginning to acknowledge the importance of quality in medical care and to see that there is a greater likelihood of getting good medical service through voluntary methods than by resort to national compulsory health insurance. Perhaps in some respects our nation-wide efforts at public education along these lines are beginning to pay off.

* * * * *

The public is extremely tolerant of professional leadership; it will accept the leadership of doctors and their medical societies even if it is not certain this leadership is entirely right. But the public is intolerant of a lack of leadership on the part of medical men in matters affecting health and medical care.

That was the burden of an observation made at a recent conference by a gentleman who should know what he is talking about.

Time and again in discussion meetings where laymen are present, either in preponderance over medical men or to the exclusion of them, we have had to listen to criticism of doctors as a professional group for alleged failure to demonstrate any lively interest or to assume any active initiative in promoting ideas and plans designed to improve health standards.

Frequently the profession has been chided for doing things which, in its better judgment, it would not think of doing under any circumstances. But far too often we as a lone representative—but by no means an apologist—for the medical profession have had to grant that these critics had more than a little truth and justice in what they said.

No one intimately concerned with the affairs of organized medicine during the last decade could have failed to notice a very impressive improvement in this regard. As of today, one can accurately say of The Medical Society of New Jersey, as probably of many other state societies, that there is no major aspect of the complex medical picture in which organized medicine is not playing an active if not a leading part. Gone are the days when we were content to sit back and let lay people take leadership in matters that are primarily our responsibility. Gone are the days when medical men looked with a jaundiced eye upon those social-minded and responsible citizens who wanted to help us meet our public responsibilities.

There is indeed something to be said for the theory that a strong leadership, even if slightly wrong-headed at times, is greatly to be preferred to no leadership at all.

James E. Bryan,
Executive Officer.

BOOK REVIEWS

Headache. By Louis G. Moench, M.D., Assistant Clinical Professor of Medicine, University of Utah School of Medicine. Pp. 207. Chicago, Year Book Publishers, 1947. $3.50.

The internist should see the patient suffering from headache first and, if he thinks it is advisable, have him checked by a specialist of his choice. Otherwise the unfortunate headache patient does his own shopping from one specialist to another until he lands in the office of a quack. "Headache is the most common complaint. It is the great social excuse to evade undesirable engagements."

The experiences of authorities like Wolf, Riley, Von Storch, Lennox, Horton are widely discussed. Instructive illustrations sketched by Dr. Moench and the authors mentioned above are of great help to the reader. Pathologic anatomy and physiology of headaches are reviewed. The author discusses spinal puncture, ventriculography, cranial nerve neuralgias, headaches of ocular and nasal origin, headaches from pathology in the neck, (such as narrowing of intervertebral foramen as a cause of nerve root irritation) and herniation of nucleus pulposus. Headaches from systemic disorders, histamine headaches and their treatment with the latest antihistaminics and most important, the clinical picture of migraine are intelligently presented. The author discusses the accepted remedies for migraine such as ergot preparations, inhalations of trichlorethylene, 100 per cent oxygen, daily injections of large doses of thiamine hydrochloride and thiocyanate which seems to be most effective in patients with an initial thiocyanate blood level of 1.5 to 2.5 milligrams. The chapter on headaches of emotional origin deserves special mention.

FELIX BAUM, M.D.

Modern Cosmeticology. By Ralph G. Harry; foreword by P. B. Mumford, M.D. 3d ed., rev. and enl. Pp. 514 with illustrations. Brooklyn, N. Y., Chemical Publishing Co., 1947. $12.

This excellently written complete book on a very complicated subject, makes clear to the reader the many physico- chemical problems involved in "beautifying preparations". No mere cook book grouping to recipes is found. Indeed, each department (hair, nails, teeth, etc.) and all the various types of lotions, creams, packs and "foods" marketed to improve them are discussed clearly and critera set up against which these trade items are measured.

The book is well edited. The glossy paper, many fine color and black and white pictures and photomicrographs make it easy to follow the text.

Physicians, students, and technicians are advised to read this thorough and modern handling of the complicated chemical problems brought to the front by the never ending search for chemical aids to beauty and health.

IRVING SHAPIRO, M.D.

A Primer of Cardiology. By George E. Burch, M.D., and Paul Reaser, M.D. Pp. 272 with 203 illustrations. Phila., Lea & Febiger, 1947. $4.50.

This little book well fulfills the promise of its title and the remark in its preface: ". . . intended for medical students and physicians . . . interested in a practical approach to cardiology." This objective is almost never lost sight of in this integrated physiologic - pathologic - clinical approach which stresses information to be gained by ordinary clinical procedures over that requiring laboratory instruments.

The authors are concerned with a thorough analysis of the common cardiac states, leaving rarities for the reference works. As a physician personally desirous of a refresher in clinical cardiology, I have found this book very helpful. The views expressed are current. The writing is compact and clear. The illustrations really illustrate. Credit is due the authors for repeating certain basic hemodynamic charts wherever relevant to the text, instead of the usual nuisance of forcing the reader to leaf back and forth as he reads.

A confusing discrepancy occurs in the text in the discussion of the treatment of syphilitic heart disease. A detailed scheme of therapy is presented as a table. This table advises use of arsenicals in a manner which the adjacent textual matter rejects sharply. This inconsistency is not explained in any way. This point, we trust, will be clarified in later printings.

BERNARD CHROMOW, M.D.

Internal Medicine in General Practice. By Robert Pratt McCombs, M.D. 2d ed. Pp. 741. Phila. and London, W. B. Saunders Company, 1947. $8.00.

The refreshing character of this volume makes it an important addition to the library of doctors in all fields. In a very convincing manner, McCombs tells us in the introductory paragraphs that diagnosis is of the first importance and relatively easily accomplished in most cases. Symptom differential diagnosis is stressed in outline form. Diagrams, color plates of eye grounds and blood smears, and pictures of x-rays are numerous. Pertinent physiologic principles are explained in a simple and appropriate manner at every opportunity. Technics of various tests are described. The very recent and important advances in therapeutic concepts (such as the use of propylthiouracil in thyroid disease and the use of the rice diet in hypertension) are mentioned in a way to bring out the essentials. The subject matter, although somewhat didactically written, is concise and clear, far beyond the usual rambling styles. Revision from the first edition has been well carried out to give a book of almost outline clarity of remarkable completeness. The physiologic approach to the subject of internal medicine makes it a living subject in contradistinction to some of the previous dry recitals of certain well known texts. The book is highly recommended for general use of the profession.

EVERETT O. BAUMAN, M.D.

Successful Marriage. By thirty-eight authors. Edited by Morris Fishbein, M.D., and Ernest Burgess, Ph.D. Doubleday and Company, New York, 1948. Pp. 547.

The layman turns too often to non-medical counsellors for advice on personal problems. In the old days, runs the lament, the family doctor was the adviser on matters of marriage hygiene, sex education and child rearing. Today, few physicians take the trouble to equip themselves to give practical advice on such matters—one reason being that the doctor has simply no place to turn for a compact reservoir of information. That excuse is no longer valid, since with this book, we do have a reference source on all phases of marriage and child guidance.

This ambitious project covers preparation for marriage, marital adjustment, pregnancy, childbirth, child guidance, divorce, remarriage, sex education, venereal disease, the climacteric and related problems. It gets off to a bad start with a chapter entitled *How Can You Tell if It's Love?* The author of this chapter, Henry Bowman, Ph.D., is addicted to the thesis that sex is the basis of "romantic love" and that this is therefore different from filial and parental love—two concepts which most psychiatrists would promptly reject. The next chapter on *The Wise Choice of a Mate,* however, recognizes more realistically the nonsexual aspects of the marital relationships. Its author—Ernest Burgess—furnishes yardsticks useful in determining the wisdom of a marital choice, and supports his thesis with strong scientific evidence. Evelyn Duvall then contributes a witty and readable chapter on courtship, followed by Dr. Anna Stephens who reviews premarital sex relationships with frankness and with a shrewd analysis of all its implications. Paul Popenoe writes an advertisement for the marriage counsellor, warning couples not to take their problems to the average physician (the M.D. degree, he explains scornfully, is not necessarily evidence of training in this field) nor to psychologists, nor to clergymen, but only to a specialist in marriage counselling. (Mr. Popenoe is one.)

The next section of the book opens with a vivid chapter on the anatomy and physiology of the genitalia, including a review of the mechanics of coitus. This is by Dr. Robert Dickinson. Dr. G. L. Kelly follows with the "Technic of Marriage Relations"—which he limits exclusively to the sexual relations of the couple. . He ignores the many other aspects—psychologic, social, etc., which are certainly part of the fabric of the marital relationship. This is taken up by Dr. O. Spurgeon English, who races through the psychologic and attitudinal aspects of the consortium in a fourteen-page chapter on "Sexual Adjustment". (One of the whimsies of the book appears to be that the chapter entitled "Technic of Marriage Relations" limits itself to sexual technics, whereas the chapter entitled "Sexual Adjustment" takes up the non-sexual aspects of it.) Mr. Lester Dearborn writes briefly about adultery—he's opposed to it. Dr. Thurman Rice discusses the health and hygiene of marriage, and while he refuses to commit himself on the twin-beds vs. double bed controversy, he does touch on bedroom hygiene, coitus among the elderly, and the timing and frequency of copulation.

Dr. Alan Guttmacher has a thoroughly competent chapter on miscarriages and abortions. Warren Spencer, Ph.D., reviews "facts and fallacies of heredity" in an adequate if unexciting chapter on the subject. Dr. Stone writes with business-like briskness of the various technics of contraception.

Elizabeth Hurlock, Ph.D., offers a good fundamental treatise in basic child psychology. Charles Manwiller (also a Ph.D.) writes a really practical chapter on sex education for children at all levels. This is continued by Katherine Taylor (who is a doctor of education) in a useful section on adolescent preparation for marriage. The section is concluded by James Bossard, Ph.D., who gives a once-over lightly to the matter of parent-child relationships. This reviewer is chagrined to note that not one of these excellent chapters had been assigned to an M.D.

Also discussed in this book (but for reasons of space not critically reviewed here) are such topics as household budgeting, juvenile delinquency, church weddings, height and weight norms for children (given in millimeters and kilograms in the tables and therefore incomprehensible to the average parent) second marriages, adopted children, stepchildren, the economics of child-rearing, social life during the honeymoon, and careers for mothers.

It is impossible to appraise the book as a unified whole, since it is an anthology by 38 authors who vary considerably in their skill with words, in the soundness of their points of view, and in the meaningfulness of their messages. On the whole, the good chapters outnumber the bad ones, the interesting ones outnumber the dull ones. There are certain physicians who ought to own the book and use it often. These include general practitioners, pediatricians, urologists, psychiatrists, gynecologists, and all physicians who think of themselves as "family doctors" or who work closely with social agencies, schools, industry, colleges or the courts. The doctor in any such classification should first leaf through the text so that he knows his way around the five "parts" and thirty-eight "chapters". Then, perhaps, he should read it more thoroughly at his leisure (it is particularly recommended for reading in bed). He will find it well worth shelf-space in his medical or personal library, as a reference work to be consulted before giving marital or child guidance advice, or before undertaking to make a public speech on any phase of family life. On the whole, it is a mature, frank, useful and readable study of its subject, and there is nothing else quite like it in the whole realm of American bibliography.

HENRY A. DAVIDSON, M.D.

COUNTY SOCIETY REPORTS

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The *Burlington County Medical Society* and the County Society's Auxiliary held their annual joint meeting on May 13, 1948, at the Riverton Country Club.

DR. E. WARREN RODMAN called the meeting to order and gave his last address as president of the Burlington County Medical Society. In his talk the retiring president expressed his thanks to all the members and committees who made his tenure of office a success. He mentioned particularly the executive committee, the program committee, the welfare committee, the public relations committee, the woman's auxiliary and the secretary, Dr. Howard C. Curtis. In closing Dr. Rodman introduced the new president of The Medical Society of New Jersey, Dr. J. Howard Hornberger. Dr. Hornberger arose and made a short speech in which he stated that he would do his best to lead the State Society successfully through his term of office.

At this point in the meeting it is the custom for the incoming president to give an acceptance speech. Unfortunately the new president, Dr. Paul R. Sparks, was confined to the Burlington County Hospital because of an emergency appendectomy. In lieu of his speech Dr. Rodman read a short note from Dr. Sparks.

The secretary, Dr. Howard C. Curtis, was also unable to attend the meeting as he too was a patient at the Burlington County Hospital due to a herniorrhaphy.

At the request of Mrs. Gerald McDonnel, Dr. Joseph M. Kuder presented to Dr. Rodman a gavel which was in memorium of Dr. Gerald McDonnel, who would have been president of our Society this past year if he had not met with a tragic and untimely death in September 1947.

Dr. Rodman read a letter from Dr. Royal A. Schaaf, the retiring president of the New Jersey State Medical Society thanking the County Society for its cooperation during the past year.

The chairman of the program committee, Dr. Dean H. LeFavor, took charge of the meeting and presented a well arranged program of entertainment. During the musical portion the entertainers requested that Dr. LeFavor join the group by performing on the piano, for which he is famous. The last part of the program featured a magician who kept his audience mystified by his many tricks and by picking the pockets of several of the members. All such articles were returned to their rightful owners.

CAMDEN COUNTY

Harold K. Eynon, M.D., Reporter

A dinner was held at the Walt Whitman Hotel preceding the regular society meeting on May 4, 1948, to honor the outgoing president, DR. JAMES S. SHIPMAN. Dr. Maldeis acted as toastmaster and managed to keep the speeches to a minimum. Dr. Shipman expressed his gratitude to the society and the physicians of Camden County for their reception of him, and for their cooperation during his term of office. Some fifty members attended the dinner.

The regular monthly meeting was called to order at 9 p. m. on the same date by the president, Dr. Shipman, the order of business being the election of officers. The following were elected: President—DR. REUBEN L. SHARP, President-Elect—DR. J. C. LOVETT, Vice-President—DR. A. M. K. MALDEIS, Recording Secretary—DR. A. G. PRATT, Treasurer—DR. K. L. ATHEY, Historian—DR. HELEN F. SCHRACK, Reporter—DR. H. K. EYNON, Trustee—DR. THOMAS B. LEE, and Censor—DR. JAMES S. SHIPMAN.

Dr. Shipman then delivered an address to the society, in which he advocated the formation of a diagnostic clinic to be established in Camden for service to Camden County, and serving to discourage group practice of medicine. He expressed an opinion that the Camden County Medical Society should sponsor such a clinic. The meeting adjourned at 10:45 p. m.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

DR. JOSEPH HUGHES presided at the regular monthly meeting of the Gloucester County Medical Society which was held at the Woodbury Country Club, May 20, 1948, at 9 p. m.

Dr. Wendell Burkett, reporting for the legislative committee, discussed the status of the professional licensing boards, and also the optometry and chiropractic bills. It was voted to donate $25 from the treasury to the School Health Council.

The following were unanimously elected for the year 1948-49: President, DR. FREDERICK J. FAUX; Vice-President, DR. J. PAUL BURKETT; Secretary, DR. CLARENCE A. BOWERSOX; Treasurer, DR. DAVID R. BREWER; Reporter, DR. LOUIS K. COLLINS; Historian, DR. DOROTHY M. ROGERS. Delegates to the State Society for three years: DR. F. G. WANDALL and DR. L. K. COLLINS. Alternate delegates for three years: DR. I. N. PATTERSON and DR. J. J. LAURUSONIS. Nominating Delegate, DR. B. A. LIVENGOOD; Alternate, DR. W. J. BURKETT.

In its report, the nominating committee suggested that delegates attend at least two complete sessions of the House of Delegates and preferably stay in Atlantic City for the entire meeting.

While appointing his committees, the new president, Dr. Faux, suggested that the program committee have an early meeting and attempt to have the entire year's program outlined for publication in the September Bulletin. Dr. Faux also requested that a discussor be named for each paper presented. The president named an executive committee to facilitate the business portions of our meetings, the following to serve: Drs. Underwood, Burkett, DiMarino, Ulmer and Hollinshed.

The other committee appointments are as fol-

lows, with the first-named serving as chairman:

Program: Drs. Collins, P. Burkett, Laurusonis, Beall.

Maternal Welfare: Drs. Underwood, Weems, Rogers.

Public Relations: Drs. Livengood, Ulmer, G. Campo.

Post-Graduate: Drs. LaRosa, Lintz, Brower.

Public Health: Drs. Wentzell, Chesley, Harris.

Legislative: Drs. W. Burkett, Patterson.

Cancer Control: Drs. Underwood, Stewart, Wandall.

School Health: Drs. Pedrick, Sheets, Brewer.

Child Health: Drs. Pegau, Beall.

Adviser to Woman's Auxiliary: Dr. Ulmer.

Despite the increase in the state dues, it was decided to keep our county dues at $30 for the ensuing year. It was also suggested that a collation be served at some of our meetings next year, in hopes that it would bring out some of our hungry back-sliders.

MIDDLESEX COUNTY

A. J. Pellicane, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on April 21, 1948, at the Roosevelt Hospital, Metuchen. The president, DR. EDWARD F. KLEIN, called the meeting to order at 9:20 p. m.

The Ethics Committee report recommended election to regular membership of DR. JAMES F. CLINTON of Parlin, on transfer from the Utah State Medical Society, and DR. JOHN F. SCALERA of South Plainfield, on transfer from the Essex County Medical Society. On proper motion, these two elections were approved.

Dr. George J. Kohut, treasurer, requested clarification of the section on pro-rating of membership dues as published in the new Constitution and By-Laws. This matter was referred to the Committee on Constitution and By-Laws.

Letter from the Honorable Bernard W. Vogel, Minority Leader of the House of Assembly of New Jersey, stating that he has voted on the oleo-margarine bill in accordance with the wishes expressed in the Resolution adopted by this Society.

The following Resolution was introduced by Dr. C. W. Naulty and on proper motion was approved:

WHEREAS, Once again it is the sad duty to announce the death of a member of our County Medical Society, Dr. John L. Lund of Perth Amboy, and

WHEREAS, Dr. Lund has been removed from our midst after a service of over half a century—during which he gave evidence of professional ability, civic righteousness, and patriotic devotion in a career marked with standards of ethics and true fraternity,

THEREFORE BE IT RESOLVED, that the Middlesex County Medical Society enter this Resolution upon the Minutes of the Society and that the Secretary be instructed to send a copy to the family of the late Dr. Lund.

The president-elect of The Medical Society of New Jersey, Dr. J. Howard Hornberger, was then introduced. He gave an interesting talk on "The Importance of the State Medical Society" and told of steps taken to advance medical care in New Jersey. He also spoke of the various functions and achievements of the State Society and how well the Medical-Surgical Plan is working here. He pointed out that the legislative bills pertinent to the welfare of the medical profession are always under constant scrutiny by the State Medical Society.

The scientific program of the meeting was devoted to a most enlightening dissertation on the subject of *"Liver Diseases"*, presented jointly by DRS. ARTURO CASILLI of Elizabeth, consultant pathologist to the Perth Amboy General Hospital, and SYLVAN E. MOOLTEN of New Brunswick, pathologist to the Middlesex and St. Peter's General Hospitals.

Dr. Casilli spoke of the physiologic functions and laboratory tests of each of the common liver diseases, while Dr. Moolten presented the pathologic and microscopic picture of each. Many excellent color plates and slides were used to illustrate this extremely instructive talk.

The regular monthly meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, on Wednesday, May 19, 1948. The meeting was called to order by the president, Dr. Edward F. Klein, at 9:10 p. m., with an attendance of approximately 100 members.

Dr. Charles Calvin, chairman of the committee on medical ethics, asked for a ruling regarding two members of the Society who have been associate members for two years—but have been out of the state for that period taking post-graduate work. On proper motion, they were considered as having fulfilled the Society's requirements since their legal residence has remained in New Jersey.

The following associate members were elected to full membership: DRS. MEYER BECKER, Metuchen; MILTON BROWN, Carteret; FRANK BRISTOL, Dayton, and MORTIMER COWEN, Iselin.

At the request of Dr. John H. Rowland, the membership heard a representative of the Hospital Service Corporation of Perth Amboy discuss the merits and advantages of group hospitalization for the Society. Discussion and further consideration was deferred until this plan could be considered by our insurance committee and compared with the other hospitalization plans.

The guest speaker of the evening, DR. HARRISON S. MARTLAND, was then presented by Dr. William C. Wilentz. Dr. Wilentz told the audience of Dr. Martland's many contributions to the medical profession, particularly in the field of industrial poisons, and of the many honors and official positions held by Dr. Martland, which included Chief Medical Examiner of Essex County, Pathologist to the Newark City Hospital, Consulting Pathologist to many other Newark Hospitals, and Professor of Forensic Medicine at the New York University (Bellevue) College of Medicine.

Dr. Martland spoke on "Violent and Natural Deaths of Interest to Surgeons and Physicians". His address was profusely illustrated with slides obtained from cases from his files, and it was with reluctance that the audience permitted him to conclude his talk after two hours.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The annual meeting for election of officers of the *Monmouth County Medical Society* was held April 21, 1948, at the Monmouth Memorial Hospital, Long Branch. The following were elected: President, DR. FRANK J. ALTSHUL; President-Elect, DR. HARRY BRINDLE; Reporter, DR. LESTER BARNETT; Executive Committee, DR. MCDONNELL, DR. FEATHERSTON, DR. WILKINS; Board of Censors, DR. K. BROWN; Delegates to the State Society, DR. WILLIAM HERRMAN, DR. ROBERT MCTAGUE; Alternate Delegates to State Society, DR. RICHARD DEMAREE, DR. WILLIAM HEATLEY; Nominating Delegate, DR. WILLIAM HERRMAN; Alternate Nominating Delegate, DR. FEATHERSTON.

An amendment to the Constitution of the County Medical Society, revising the classification of members was presented and passed.

The members of the society were notified about the formation of a telephone exchange for night and emergency calls. Any member interested should fill out a form which he will receive, stating what nights he will be available and mail the form to Mr. Gorman.

Announcement was made of the procurement of group hospitalization. Members are requested to notify Mr. Gorman if they accept the hospitalization plan.

The following doctors were elected to full membership: DR. JOHN TILLEY of Keyport, DR. GEORGE BRUZZA of Sea Girt, and DR. FRANCIS GUITO of Asbury Park.

The scientific program, which then followed, was featured by a talk by DR. HERBERT ADAMS of the Lahey Clinic in Boston, on surgery of the upper gastro-intestinal tract.

Lester Barnett, M.D., Reporter

The regular monthly meeting of the *Monmouth County Medical Society* was held on May 26, 1948, at the New Jersey State Hospital, Marlboro, in conjunction with the New Jersey Neuropsychiatric Association. Invited to the meeting were physicians on the staffs of the State Hospitals at Trenton and Greystone Park, and the Skillman Village.

DR. EDWARD WEISS, professor of clinical medicine, Temple University, Philadelphia, spoke on *Psychosomatic Medicine.* The absorbing talk was well received by the audience and discussed by DR. JEROME KAUFFMAN, associate professor of clinical medicine, New York University, DR. FRANK ALTSCHUL, president-elect of the county society, DR. KARL ROTHSCHILD, New Brunswick, and DR. FRANK PIGNATARO, Red Bank.

A brief business meeting followed. Elected to full membership were DR. JOHN B. MOVELLE of Fairhaven and DR. RICHARD B. BRAHM of Sea Girt. Elected to associate membership were DR. JOSEPH M. TOBIN of Marlboro, DR. EDWARD F. KELEMEN of Long Branch, and DR. HENRY A. SCHIELDS of Highlands. Group hospitalization for the members was discussed and an Emergency Call Service to provide the county with more adequate physician coverage, was explained. DR. HARRY R. BRINDLE outlined the program for the Annual Outing to be held at the Manasquan River Golf Club, Brielle, on June 23, 1948. DR. LOUIS F. ALBRIGHT, president, presided at this last regular meeting of the year.

SOMERSET COUNTY

H. E. Cook, M.D., Reporter

The regular monthly meeting of the *Somerset County Medical Society* was held on Thursday evening, May 13, 1948, at the Somerset Hospital Nurses Home with DR. GEORGE E. BARBOUR presiding.

A letter from the State Department of Health was read requesting County Society approval of DR. HAROLD N. WENDER to head the Baby-Keep-Well-Clinic of South Bound Brook.

The secretary read a letter from the First Army Surgeon's Office, Headquarters U. S. A., Governors Island, N. Y., expressing the urgent need for doctors, dentists and nurses.

The president announced the proposed meeting of the National Council of County Medical Societies to be held at the forthcoming A.M.A. Annual Session.

Dr. Samuel H. Pogoloff reported on the activities of the recent N. J. State Society Convention.

Dr. Pogoloff was then called upon to bring the Society up to date on the new school health program.

The president appointed DR. EMERSON HIRD, DR. LEWIS C. FRITTS and DR. SAMUEL H. POGOLOFF as the nominating committee for the officers of the coming year.

Dr. George A. Glass was called upon to report on the projected program scheduled for the coming year. The prospect of some very interesting meetings seems assured.

UNION COUNTY

E. M. Satulsky, M.D., Reporter

Under the chairmanship of Dr. Davis, its president, the *Union County Medical Society* held its annual meeting at the Plainfield High School, Plainfield, April 14, 1948.

The following applicants were elected to membership: DR. JOSEPH E. MAST of Roselle Park; DR. H. HILLMAN PALMER of Rahway; DR. GEORGE P. POTEKHEN of Plainfield; and DR. J. J. REILLY of Elizabeth. DR. J. S. DENHOLM of Elizabeth was accepted for membership by transfer from the Amamance-Caswell Counties (North Carolina) Medical Society; DR. ALBERT HIRSCH of Rahway and DR. JONAS WEISSBERG of Elizabeth were accepted for membership by transfer from the Bronx County (New York) Medical Society.

It was moved that Miss Rogers be reappointed executive secretary.

It was moved that the matter of the listing of osteopaths in the telephone directory be referred to the Public Relations Committee with power.

Letter received from the chairman of the State Society committee on conservation of vision and hearing requested the support of our Society in opposing certain parts of substitute bill S-171 (optometry bill). It was moved that the recommendation now before the Assembly be opposed by the

County Society and that each Assemblyman be so notified.

The proposed amendment to the Constitution and By-Laws on the nominating committee was read: Article III, Section 10, reads as follows: "It shall be the duty of the Nominating Committee at the annual meeting, to present to the Society, a list of candidates for the several offices, committees and delegates, excepting for members of the Nominating Committee, who shall be nominated from the floor at the previous regular meeting."

The following change is proposed to the By-Laws of the Union County Medical Society; the phrase, "who shall be nominated from the floor at the previous regular meeting", shall be stricken from the sentence. A new sentence shall read: "The Nominating Committee shall be composed of seven men. One member shall be the junior past president of the Union County Medical Society, and one member from each hospital staff to be elected by the respective hospital staff. The secretary of the hospital staff shall certify their member to the Secretary of the Union County Medical Society at, or before, the last regular meeting previous to the annual meeting".

It was moved that the action in endorsing one candidate for second vice-president to the State Society be rescinded and that the delegates go to the State Society meeting entirely uninstructed until a caucus in Atlantic City. It was moved that the executive secretary be empowered to inform the secretaries of all the county medical societies of this action.

Dr. Griswold, chairman, presented the report of the nominating committee. An alternate slate was offered from the floor. The following officers were elected: *President,* DR. R. M. NITTOLI; *First Vice-President,* DR. F. W. LATHROP; *Second Vice-President,* DR. H. S. MURPHY; *Secretary,* DR. E. G. BOURNS; *Treasurer,* DR. G. T. BANKER, and *Reporter,* DR. E. M. SATULSKY. *Trustee,* Dr. E. P. Weigel, 1951; *Board of Censors,* Dr. L. B. Armstrong, 1953; *Scientific and Literary Work Committee,* Dr. M. L. Griswold, Jr., Dr. G. McK. Stevenson and Dr. L. M. Townsend; *Finance Committee,* Dr. Foster Orton, 1951; *Legislative Committee,* Dr. Walter F. Phelan, 1953; *Public Health Committee,* Dr. Frances H. Arthur, 1953; *Public Relations Committee,* Dr. C. C. Carpenter, 1953; Dr. J. E. L. Imbleau, 1952 (unexpired term); *State Nominating Committee,* Dr. Emil Stein; *Alternate,* Dr. N. W. Burritt. *Delegates,* term expires 1951; Dr. A. R. Casilli; Dr. S. H. Davis; Dr. M. L. Griswold, Jr.; Dr. D. P. Lieberman; Dr. George Knauer; Dr. L. H. Leggett, Jr., Dr. Jacob Reiner; Dr. C. H. Schlichter; and Dr. E. P. Weigel. *Alternates,* term expires 1951; Dr. E. J. Callahan; Dr. J. G. Boyes; Dr. N. S. Deutsch; Dr. E. E. Feleppa; Dr. W. M. Golden; Dr. C. A. Hoffman; Dr. S. H. Carsley; Dr. R. J. Holland; and Dr. F. A. Williams.

Dr. Davis as retiring president gave an address in which he stressed the increasing amount of work done by the committees and of their importance. He expressed his appreciation to all of the members and asked them to continue their cooperation with the new president.

Dr. Nittoli accepted the chair from Dr. Davis and spoke briefly on future plans for the Society.

The meeting then adjourned.

WARREN COUNTY

Joseph C. Humbert, M.D., Reporter

The *Warren County Medical Society* held its regular meeting at Altieri's Restaurant, Washington, on June 15, 1948, DR. FRANK BARTOLINI presiding.

DR. JESSE SCHULMAN, Belvidere, and DR. DOREEN COOKE SHEFFIELD, Oxford, were elected to membership.

A committee appointed to meet with the Red Cross about the Hackettstown Blood Donor Project reported that the features of the plan to which the society had objected had been changed satisfactorily. The society therefore agreed to sponsor the project. Dr. A. C. Zuck, chairman of a committee to explore possibilities for the construction of a hospital for the chronically ill, reported that there were federal funds available to partly pay for such a project but most of the cost would have to be paid by the county. After a discussion joined by State Senator Robert Meyner, P. R. Thatcher and Irving Engleman from the County Welfare Board, and others, it was generally agreed that the type of hospital required to get federal aid would be so expensive that the Board of Freeholders would never approve of it. The society decided to investigate other approaches to the problem.

A formal agreement between the society and the County Welfare Board being necessary to make funds available for medical fees for relief patients, a committee was appointed to handle the matter.

Easton Hospital, Easton, Pa., has recently barred local physicians without Pennsylvania licenses from its staff. The secretary was instructed to write several interested agencies for further information about this action.

NEW JERSEY OBSTETRICAL AND GYNECOLOGICAL SOCIETY

B. Daversa, M.D., Secretary

The *New Jersey Obstetrical and Gynecological Society* held its first annual meeting in April at the Trenton Country Club. Two hundred and fifty members and guests attended the afternoon session to hear DR. HENRY C. FALK speak on the subject *The Gynecologist Looks at Cancer of the Uterus* and DR. ROBERT MACKENZIE speak on *Preventable Factors in Maternal Mortality.* The evening session consisted of a dinner followed by an illustrated talk on *The Surgical Care of Urinary Incontinence in Women* by DR. RICHARD W. TELINDE.

At the business meeting the following officers for 1948 were unanimously elected: *President,* DR. HERSCHEL MURPHY; *President-Elect,* DR. GEORGE B. GERMAN; *Vice-President,* DR. J. CARLISLE BROWN; *Secretary-Treasurer,* DR. BENJAMIN DAVERSA.

At the close of the evening session the retiring president Dr. Samuel A. Cosgrove was roundly applauded by the membership for having so well steered the progress of the society in its first year of existence.

WOMAN'S AUXILIARY

EXECUTIVE BOARD MEETINGS

Mrs. Banks S. Baker, Recording Secretary

The Pre-Convention Board Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held in the Solarium of Haddon Hall, on Tuesday, April 27, 1948.

The meeting was called to order by the president, Mrs. Lodovico Mancusi-Ungaro.

The minutes of the March meeting were approved as read.

The treasurer, Mrs. G. E. McDonnel, submitted a statement showing a balance of $1,-558.38 which was filed for audit.

Communications were read by the corresponding secretary, Mrs. Philip J. Santora.

Reports were submitted by the president, committee chairmen and county presidents.

Mrs. Chester I. Ulmer and Mrs. Thomas P. McConaghy were appointed to serve on the auditing committee, Mrs. McConaghy to act as chairman.

The resignation of Mrs. Norman Nathanson as a Director was accepted. Mrs. Thomas H. McGlade was nominated to fill the unexpired term.

The president announced that the parliamentarian, Mrs. William E. Dodd, is calling a meeting of the presidents of the newly organized counties immediately following this meeting.

There being no further business the meeting adjourned.

The Post-Convention Board meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held in the Solarium of Haddon Hall on Thursday, April 29, 1948.

The meeting was called to order by the president, Mrs. Robert B. Walker.

The minutes of the Pre-Convention Board meeting were approved as read.

The treasurer, Mrs. G. E. McDonnel, submitted a statement showing a balance of $1,-342.29 which was filed for audit.

Mrs. Thomas P. McConaghy, finance chairman, read the tentative budget.

Mrs. Asher Yaguda moved that the president call a meeting of our Advisory Board, the finance committee, and a representative of the finance committee of the Medical Society for the specific purpose of itemizing our budget to suit the Board of Trustees. Seconded by Mrs. McDonnel and carried.

Mrs. Walker announced the committee appointments as approved by the Advisory Board and the executive committee.

The president presented her program for the year as approved by the Board of Trustees.

Under Point No. 3 Mrs. Walker called on Mrs. Yaguda to explain the Rural Health Conference to be held on June 7.

The question of recognition for newly organized counties was discussed. Mrs. Carlander moved that the president appoint a committee comprising Mrs. Allman, the organization chairmen, the parliamentarian, and the revisions chairman to study this matter and to bring a recommendation to the Board for action. Seconded by Mrs. Davis and carried.

The president called attention to the Public Relations program on June 7 and the Conference-Workship on June 14.

Mrs. Lodovico Mancusi-Ungaro moved that this body go on record as approving Mrs. Walker's ten-point program for the year and that we work under it.

There being no further business, the meeting adjourned.

WORKSHOP CONFERENCE

Mrs. Thomas H. McGlade, Chairman, Press and Publicity

Mrs. Robert B. Walker, state president, completed another part of her ten-point program with the Workshop Conference held June 14, 1948, at the Medical Society Executive Offices in Trenton. Sixty-five members were present and took part in the various discussion groups during the morning session.

After the luncheon hour, Mrs. Norman Nathanson, conference chairman, introduced Dr. William E. Dodd, Medical Society Adviser to the Auxiliary. Dr. Dodd stated it was only through cooperation and combined efforts that we produce results and offered his continued service to the Auxiliary. The chairmen of Bulletin, Hygeia, Legislation, Public Relations, Publicity and Widows and Orphans Committees gave summaries of the morning discussions to the general assembly.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **July, 1948** **No. 7**

THE first step in the eradication of tuberculosis is to find the persons who already have active pulmonary tuberculosis. If case finding is not carried on constantly it does little good for the community to provide hospital beds and other services, necessary as they are. For the persons who should use them will still be engaged in the ordinary activities of life in the community. When symptoms of tuberculosis appear it is usually too late to have prevented the spread of the disease and the best opportunity for effective therapy is gone.

TUBERCULOSIS CASE FINDING

Selective Service boards after mass X-ray study of all inductees showed that 90 per cent of the men rejected for tuberculosis had minimal disease, whereas almost 90 per cent of the patients admitted to the sanatoriums in this country have advanced disease.

Adults, rather than children, are chiefly responsible for the spread of tuberculosis. Public health laws should insist on the mass X-ray examination of all school teachers, food handlers and domestics —a surprising number of whom are admitted to sanatoriums. Tuberculosis is found more frequently in certain occupations than in others. The danger of silicosis and tuberculosis is well known, and much has been done to control the hazard of silica dust.

Student nurses and physicians are often exposed to infection in their daily duties. Every patient admitted to a general hospital should have an X-ray examination of the chest. If this were done, it is believed that the prevalence of tuberculosis among medical students and nurses would be reduced.

Reports have shown a high incidence of tuberculosis among inmates of mental hospitals. These patients are a source of danger not only for other inmates but also for the attendants. Tuberculosis is also prevalent among the inmates of prisons. The confinement and frequent overcrowding of these institutions gives an opportunity for the disease to spread. Since many prisoners are later discharged to their homes and communities the danger is obvious.

It is an accepted fact that decent housing, an adequate diet and an acceptable standard of living are necessary to keep down the tuberculosis rate. If the disease is to be eradicated, greater effort will have to be made to abolish slum areas and crowded tenement districts.

Industry must play its part in the reduction in the morbidity and mortality of tuberculosis. A preemployment examination, including an X-ray film of the chest, should be required. Well established standards for ventilation, sanitation, health education and personal hygiene should be enforced.

The heavy economic and financial burden on the taxpayer of a long hospitalization is not fully realized by the general public. Case finding is a sound investment for any community. The earlier the case is diagnosed, the shorter the period of hospitalization. In addition, the number of cases will be definitely reduced, for the earlier segregation of the patient prevents spread of the disease to the family and the community.

The opportunity of practicing physicians to find cases of tuberculosis is unquestionably greater than that of any agency. It is regrettable when patients are admitted to sanatoriums with far advanced tuberculosis after having been under treatment for months for chronic bronchitis. It is a safe policy for the physician to insist on an X-ray film of the chest whenever a patient's cough persists for more than two weeks. Any physician who waits to make a diagnosis of tuberculosis by auscultation imposes a grave responsibility on himself—nine out of every 10 cases by that time are in the advanced stage.

It is no credit to a physician when an X-ray film of the chest shows existing tuberculosis after numerous cough mixtures have failed.

Again, the physician will find it advantageous to insist on an X-ray examination of the chest every six months on all diabetic patients. The high incidence and rapid spread of tuberculosis in diabetic patients are well known. It is further recommended that a chest X-ray film be taken in all cases of pneumonia approximately three months after the patient has fully recovered from the illness, since it has been shown on numerous occasions that an attack of pneumonia has been the responsible agent in lighting up an old inactive tuberculous lesion.

The board of health has a responsibility for those unable to obtain the services of a physician and also a responsibility to the physician to provide diagnostic facilities. The physician should report all cases of tuberculosis to his board of health as soon as the diagnosis is established.

The medical graduate is often told that tuberculosis is a waning disease that will completely disappear in a few years; medical students 25 years ago heard the same story. Tuberculosis is still the most serious health problem confronting any state or community. One cannot overlook the fact that there are still about 500,000 cases in the United States, that tuberculosis is the leading cause of death between the ages of 20 and 40 and that on the average nearly 60,000 persons die of tuberculosis every year.

It is obvious that the crux of any program of tuberculosis control is early case finding by mass X-ray study and immediate segregation of the patient until he is well enough to return to his family and community. If a reduction in the mortality and morbidity from tuberculosis is to be achieved, the full support and cooperation of the general practitioner, the public, industry and public-health agencies are absolutely essential.

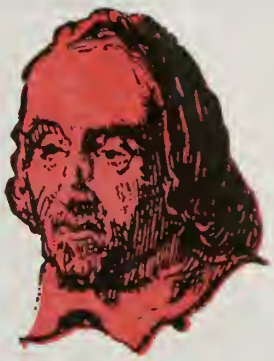
Tuberculosis Case Finding, John A. Foley, M.D., and John B. Andosca, M.D., The New England Journal of Medicine, December 5, 1946.

SUPPLIED BY

NEW JERSEY TRUDEAU SOCIETY,
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BAYONNE	Nelson W. Dittmar, 924 Broadway	BAyonne 3-0406
BLOOMFIELD	Burgess Chemist, 56 Broad St.	BLoomfield 2-1006
BLOOMFIELD	H. H. North, Ph.G. Phar.D., 417 Broad St.	BLoomfield 2-0326
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	Bound Brook 150
EAST ORANGE	The Professional Laboratory, 144 So. Harrison St.	ORange 5-7430
ELIZABETH	Kerner's Prescription Pharmacy, 504 Court St.	ELizabeth 3-9497
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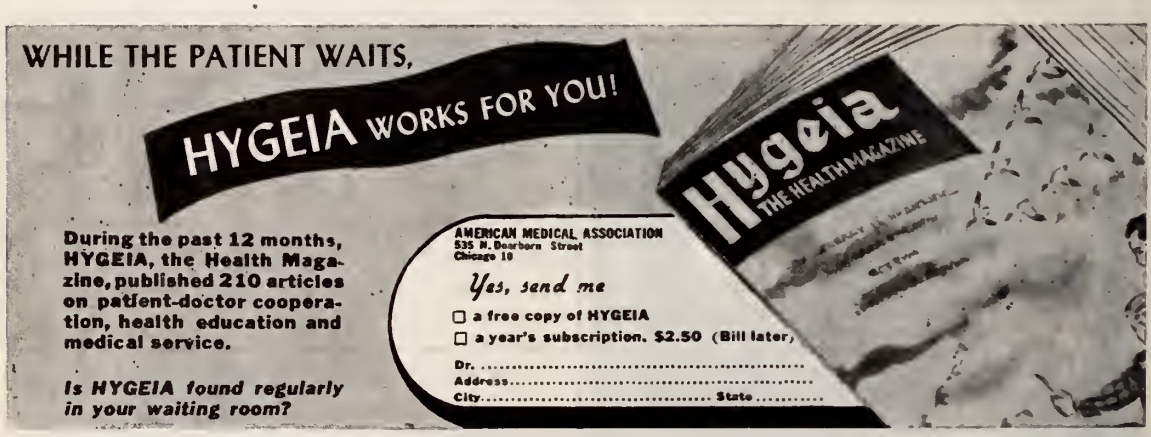
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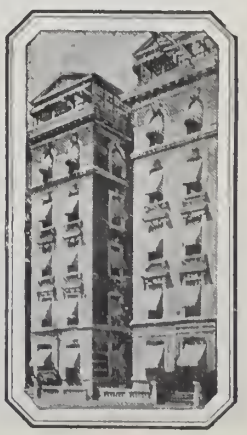
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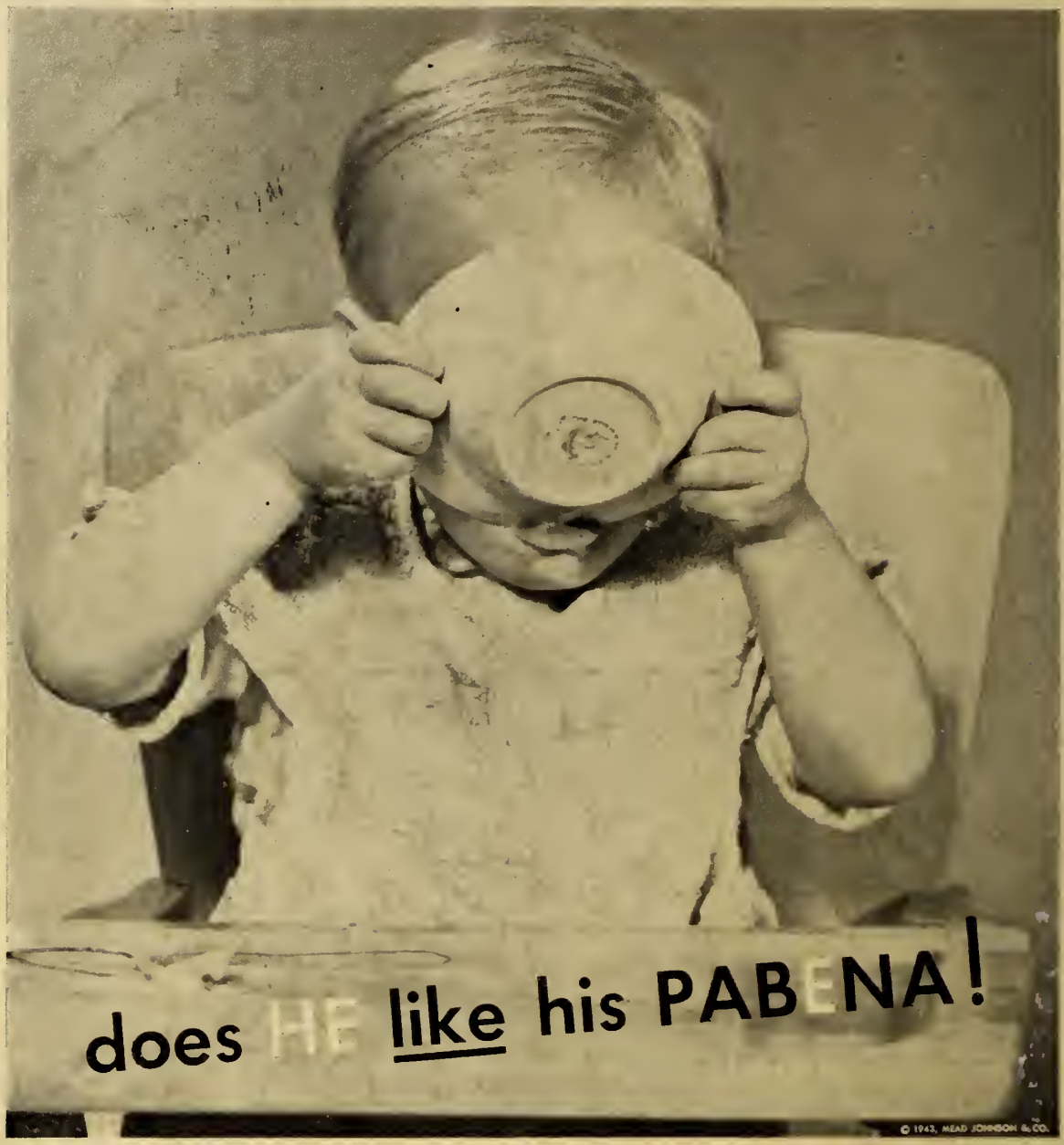
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MINUTES OF THE HOUSE OF DELEGATES

Monday Afternoon Session—April 26, 1948

The One Hundred Eighty-Second Annual Meeting of the House of Delegates of The Medical Society of New Jersey convened at Haddon Hall, Atlantic City, at 2:40 p. m., Dr. Royal A. Schaaf, President of the Society, presiding.

President Schaaf: The meeting will please be in order. I feel highly honored to have the opportunity to welcome you delegates to this opening session. We have an excellent program, the details of which appear in the program. During the past year the Trustees authorized the development of eight additional sections. Thus, we now have fourteen instead of six. In addition, we have revived the scientific exhibits and continued the ever-popular commercial exhibits. I take this opportunity to express to our Convention Manager, Mrs. Madden, our appreciation of the time and effort she has put into the work of the Annual Meeting and congratulate her upon the success of her efforts. I am delighted to offer a little tribute to her from the Society.

(Amid the applause of the delegates, President Schaaf pinned a corsage on Mrs. Madden's shoulder.)

President Schaaf: We will call on Dr. Lewis, Chairman of the Reference Committee on Credentials, for his report.

Dr. Lewis: One hundred seven delegates registered up to about ten minutes ago.

President Schaaf: Dr. Norton has been designated parliamentarian for these sessions of the House of Delegates. I now ask the secretary whether there is a quorum present, a quorum consisting of twenty members from four component societies.

Secretary Wood: A quorum is present.

President Schaaf: Thank you. You have all received in the *Transactions* of the 1947 Annual Meeting the full minutes of that session, and a motion to approve these minutes as published is in order.

(A motion was made to approve the 1947 minutes. The motion was seconded, put to a vote and carried.)

President Schaaf: It is now my pleasure to present delegates from neighboring societies. I call upon Dr. Kenney, from New York state, to take a bow and say a word to us. (Applause)

Dr. J. Stanley Kenney (New York City): Dr. Schaaf, officers of the New Jersey Medical Society, delegates and my many friends in New Jersey: it really is a great personal privilege for me to come to these meetings, whether I am here officially or just come on my own, because I have some roots in New Jersey. I was educated in Montclair, went to school all my life there until I went to college; and I have a good many friends I see in your group with whom I either went to medical school or interned with in Bellevue, so that it is always to me a personal pleasure to be here. I bring you the greetings of the New York State Medical Society, its council and its officers. Dr. Bauer himself would certainly have been here but for the fact that the new World Medical Association and its council is having an organization meeting in New York this week and he is a member of that council.

Dr. Anderson, our genial secretary, who has been here for the last few years, would also have been here but the Connecticut State Medical Society conflicted with this meeting, and he is in New Haven; and that was my good fortune to get down here. I bring to you the greetings from both of those gentlemen. We in New York are happy over the cordial relations that exist between our two state societies. We face many common problems on which state lines should not be a boundary. While each state, of course, has its own peculiar problems, there are broader questions facing the profession today. I sometimes think that a little closer association between contiguous states like New York, New Jersey and Pennsylvania might bring a more concerted point of view, so that when we appear before our national House of Delegates each year we might present a stronger front if we got together and shared our views.

In New England they have an unofficial body that meets two or three times a year, representing the officers of the six New England societies. I suggest that perhaps through some kind of a conference, once or twice a year between New York and New Jersey, perhaps Pennsylvania, we might form a more solid front in trying to resolve some of our problems, such as questions of non-profit medical defense insurance and the distressing but waning difficulties we are having with the Veterans Administration.—problems that we all have to face with the unhappy intern situation and the so-called doctor shortage. I am chairman of the Planning Committee for Medical Policy in New York, and know the work our state is doing in the expansion of the public health and hospital units under the provisions of the Hill-Burton Act. These are examples

of common problems that know no state frontiers.

I have a strong feeling about the situation between the hospitals and the medical profession; the inequalities that exist and the failure to have the medical services rendered as hospital services properly recognized, and the place the general practitioner should have, and the undue influence and I almost might say malign influence that the specialty Boards are having by excluding worthy practitioners from positions that they have every reason to occupy.

Socialized medicine is far from dead and it would do us well to address ourselves and listen in at the conference that Mr. Ewing is perpetrating on the country next week. From the advance notices, it doesn't sound like a project that is going to be very helpful. It is simply another effort of the government to propagandize for state medicine. It reminds me of the federal workshops propaganda carried on by the Social Security Board in the national health program in 1946.

So, gentlemen, with these few words I bring you the greetings from New York and I shall be happy to remain and listen with great interest to your deliberations. Thank you.

President Schaaf: We are sorry that Dr. Reuling isn't able to be here today, but we are hopeful that he will attend Wednesday. The delegates from Connecticut were unable to attend because of a simultaneous meeting of their Society at this time.

We will now proceed to the consideration of the annual and supplemental reports.

The report of the President appears on page 164 of the April Journal, and there being no supplemental report this will be referred directly to Reference Committee A.

The report of the Secretary, page 165 of the Journal was submitted by our Secretary, Dr. Wood. There being no supplemental report, the original report will be referred to Reference Committee A.

The report of the Treasurer is on page 165 of the Journal. Dr. Young has a supplemental report.

Dr. Young: I present this, your treasurer's report, for this fiscal year through last Friday, April 23. When our fiscal year started on June 1, 1947, we had a balance of $126,154. Since that time, the receipts, (taking into consideration the assessments from the twenty-one counties, accounts receivable from 1946 and 1947, the small amount of interest and unexpected revenue and other factors) amounted to $127,190. Since last June, the disbursements, [taking into consideration the payment and the getting off of our books about thirty-eight budgetary items] amounted to $108,963, leaving us a cash balance as of April 23rd of $144,381. The permanent capital fund remains exactly the same as it was last June, namely $15,065.25.

1947-1948

TREASURER'S REPORT

George J. Young, M.D., Treasurer, Morristown

Balance, June 1, 1947 ..... $126,154.58

RECEIPTS

June 1, 1947 - April 23, 1948

Assessments:		
Atlantic County	$ 2,860.00	
Bergen County	7,745.00	
Burlington County	1,400.00	
Camden County	4,580.00	
Cape May County	760.00	
Cumberland County	1,385.00	
Essex County	26,465.00	
Gloucester County	1,245.00	
Hudson County	11,410.00	
Hunterdon County	560.00	
Mercer County	5,375.00	
Middlesex County	3,835.00	
Monmouth County	3,151.25	
Morris County	2,872.50	
Ocean County	680.00	
Passaic County	9,180.00	
Salem County	460.00	
Somerset County	1,575.00	
Sussex County	640.00	
Union County	8,965.00	
Warren County	720.00	
		95,863.75
1946-47 Accounts Receivable		803.91
Interest		168.75
Revenue Unexpected		78.45
Journal Advertising (net)		23,449.08
Sale of Maternal Welfare Books		321.50
Permanent Capital Fund		386.75
Commercial Exhibits (net)		6,118.37
		$253,345.14

DISBURSEMENTS

June 1, 1947 - April 23, 1948

Budget Accounts:		
A- 1—Executive Salaries		$ 10,333.33
A- 2—Executive Office Salaries		10,636.59
A- 3—Executive Office Expenses		1,727.53
A- 4—Executive Travel		1,742.55
A- 5—House Maintenance		4,970.51
A- 5a-Library		44.70
A- 6—Treasurer		10.51
A- 6a-Remission of Dues:		
Atlantic County	$ 713.00	
Bergen County	1,572.00	
Camden County	625.00	
Cape May County	122.00	
Essex County	6,600.00	
Hudson County	1,147.00	
Mercer County	1,611.00	

Middlesex County ..	757.00	
Monmouth County ..	540.00	
Morris County	650.00	
Ocean County	150.00	
Passaic County	1,983.00	
Union County	975.00	
		17,445.00
A- 7—Finance and Budget Committee.		66.36
A- 8—Bonding		200.00
A- 9—Audit		400.00
A-10—Secretary		890.68
A-11—Unemployment Compensation Taxes		220.42
Social Security Taxes		214.91
Salary Excise Taxes		75.65
A-12—Insurance		295.63
C- 2—Welfare Committee		613.08
C- 3—Legislative Committee		5,981.89
C- 4—Public Health Committee		374.61
C- 5—Public Relations Committee		4,424.26
C- 5a-New Jersey Health Congress		478.94
C- 6—Medical Practice Committee		700.63
D- 1—President		531.67
D- 2—A.M.A. Delegates		980.75
D- 3—Dues		50.00
D- 5—Fall Clinical Conference		904.65
D- 8—Woman's Auxiliary		2,932.45
D-11—Medical Service Administration..		4,160.00
D-13—Post-Graduate Education Committee		.27
D-15—Veterans Liaison Committee		1,414.33
E —Contingent Fund		2,514.26
H —Pension Fund		1,250.00
		$ 76,586.16
JOURNAL PUBLICATION ACCOUNTS:		
B- 1—Publication		$ 21,053.57
B- 2—Cuts		41.14
B- 3—Editor's Salary		1,000.00
B- 4—Editorial Office Salaries		3,750.00
B- 5—Editorial Office Expenses		386.13
B- 6—Editorial Travel		36.05
		$ 26,266.89
1946-47 Accounts Payable		$ 1,357.20
Permanent Home Account		4,753.15
		$108,963.40
Cash Balance, April 23, 1948		144,381.74
		$253,345.14

PERMANENT CAPITAL FUND

	June 1, 1947	April 23,1948
Cash	$ 3,584.48	$ 3,197.73
U. S. Savings Bonds, Series G.	11,500.00	11,500.00
Trenton Mortgage Service Company	367.52	367.52
	$15,452.00	
To General Cash	386.75	
	$15,065.25	$15,065.25

PRESIDENT SCHAAF: Thank you, Dr. Young.

This report will be referred, along with the original report, to Reference Committee B. The report of the Board of Trustees is on page 165 of the April JOURNAL. Dr. Crowe, the chairman has a supplemental report.

DR. CROWE: Mr. President, I would like Mr. Bryan to read my report for me.

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES

There has been some criticism of the Society because there is no group within the organization to which complaints from lay groups can be referred. The Trustees recommend that this be referred to the Reference Committee on Constitution and By-Laws for consideration.

Clarification is needed of Article VI of the Constitution "The Board of Trustees shall be the executive body, and shall be composed of the *junior* Past-President, etc." This wording is indefinite as the junior Past-President serves on the Board of Trustees during the first year following termination of his administrative year. With reference to the current Board of Trustees, the junior Past-President, Dr. Scammell, died before completing his term as a member of the Board, which left a vacancy. One interpretation of this Article is that in the event of death or incapacity of the junior Past-President the vacancy on the Board is not to be filled. By another interpretation, the Article might mean, or should be amended to read "the *immediate* Past-President, if living or able to serve".

The Board of Trustees recommends that the clarification of Article VI of the Constitution be referred to the Reference Committee on Constitution and By-Laws for study and appropriate action.

PRESIDENT SCHAAF: We shall refer that to the Reference Committee on Constitution and By-Laws.

MR. BRYAN: We have received a communication from Dr. Henry A. Brodkin of Essex County, which reads as follows:

In view of the approaching Annual Meeting of The Medical Society of New Jersey, I suggest the consideration of a vital problem that may affect the well-being of millions of people. This question can be placed on the agenda of the Board of Trustees for their consideration and their recommendation could be brought before the Annual Meeting for instructions to our A.M.A. delegation.

Everyone has been horrified by the revelations at the Nuremberg trials which revealed that physicians in Germany had utilized their professional knowledge in crimes against humanity. As doctors, they blindly followed the dictates of their lay political authorities. Today we witness the emergence of a growing danger that may involve the participation of the medical profession. I speak of biologic and bacterial warfare. Our country

should carry on intensive research by scientists on this subject and be prepared against such an eventuality both defensively and offensively. However, our State Society and the A.M.A. should take the initiative officially to outlaw such methods of warfare. We as a profession should deny the participation of our members in this type of human destruction because of our humanitarian role and our traditions in combating disease.

I understand that the Medical Department of the French Army has refused participation of its members in the study of bacteriologic warfare. The Congress of Microbiology has issued a directive forbidding its members to participate in such a program. Other national societies in other countries intend to appeal to the World Health Organization for a similar purpose. It would be more fitting for organized medicine of the United States to assume leadership on this question.

Inasmuch as nothing has been done so far, perhaps New Jersey will assume the initiative.

Having witnessed the war at first-hand, I appreciate its worst features. As a profession we can protest against a method of warfare which will affect non-belligerents. As Chief of the Surgical Service in a general hospital overseas, I had under my care on an average of 400 wounded enemy patients for over 6 months. We cared for them medically in the same manner as we did our own troops. This was in the tradition of our profession. It is my hope that we can now act in accordance with our fine tradition and aims before emotions will distort our judgment and declare that bacteriologic warfare is inhumane and that the medical profession will take no part in it.

Even the Nazis when they were faced with defeat did not resort to chemical warfare. If nations at war could refrain from chemical warfare they can more easily refuse to participate in the technic of bacteriologic warfare. I wish this question could be discussed now when this new technic is being publicized and that we outlaw it now in peace time rather than wait until our passions blind us from our natural humane traditional regard for human life.

As you know, I am in charge of the Medical Department of the New Jersey National Guard and firmly believe that we should maintain our country in a state of adequate preparedness. However, as a physician, I believe that if we can possibly do it, we should try to keep the methods of warfare as humane as possible, particularly when it involves non-belligerents.

PRESIDENT SCHAAF: There is no resolution accompanying this and therefore a motion would be in order for the appointment of a committee to draft a resolution for presentation to the Reference Committee on Resolutions and Memorials. May I have such a motion?

(Motion was made and passed.)

PRESIDENT SCHAAF: Mr. Bryan will now read a resolution adopted by the Trustees this morning.

MR. BRYAN: This resolution concerns Senate Bill S-23 now pending in the State Legislature, with particular reference to the State Board of Medical Examiners. The resolution reads as follows:

Whereas, The Medical Society of New Jersey is rightly proud of the 58-year record of the New Jersey State Board of Medical Examiners in the elevation of standards of medical education and practice in this state, and

Whereas, The Medical Society of New Jersey has recommended, sponsored and worked for every progressive legislative enactment to elevate the standards of medical licensure and to support or further the work of the State Board of Medical Examiners, and

Whereas, The Medical Society of New Jersey is determined to exert every effort to insure that the State Board of Medical Examiners shall be kept free of political entanglement or interference in its vital function of protecting the public welfare in matters of medical practice, and

Whereas, the state administration has proposed, in Senate Bill No. 23, to place the State Board of Medical Examiners, together with other professional licensing boards, under the supervision and control of the Secretary of State, and

Whereas, this proposal would effectively destroy the integrity and autonomy of these professional boards by subjecting the State Board of Medical Examiners to the domination of an officer chosen traditionally for his political gifts and capacities, and

Whereas, the disposition of the State Board of Medical Examiners, and its companion boards, as proposed in S-23 cannot be justified on the grounds of efficiency, economy or logic, and

Whereas, eleven of the professions * represented in eight of the examining boards have unanimously protested this proposal, and unanimously recommended that these boards be placed together in a separate principal Department of Professional Boards, therefore be it

Resolved, by The Medical Society of New Jersey, in 182nd Annual Meeting assembled, that we hereby make known our unalterable opposition to that portion of S-23 and that we oppose it with all the influence at our command; that we condemn the proposal to subject the State Board of Medical Examiners to the supervision and control of a government agency operated by the chief politician of the dominant machine; that we emphasize the fundamental necessity, in the public interest, of maintaining the professional integrity and the administrative autonomy of the State Board of Medical Examiners and comparable professional boards; that we reiterate our well considered alternative proposal for a separate Department of Professional Boards; and that we urgently solicit the support of all other agencies and persons concerned with the maintenance of standards of medical licensure in New Jersey in defeating the dangerous and insup-

* Architects, chiropodists, doctors of medicine, dentists, veterinarians, public accountants, nurses, pharmacists, optometrists, chiropractors, and osteopaths.

portable principles embodied in that portion of S-23; and be it further

Resolved, that copies of this resolution be sent to the Governor, to all members of the State Legislature, to the press, and to all cooperating agencies in the field of public health and welfare.

PRESIDENT SCHAAF: This resolution, having been approved by the Trustees this morning, will be referred to the Reference Committee on Resolutions and Memorials.

MR. BRYAN: The following resolution relates to the World Health Organization.

Whereas, the World Health Organization of the United Nations is potentially one of the most important agencies in promoting world peace, as well as in safeguarding and enhancing world health and welfare, and

Whereas, the United States was a leader in the formation of the World Health Organization at San Francisco in 1945 and subscribed to the Constitution of the World Health Organization in New York in 1946, and

Whereas, in 1947 the United States Senate enacted a bill to make the United States a signatory to the World Health Organization and the Committee on Foreign Relations of the House of Representatives has approved a similar bill, and

Whereas, the Committee on Rules of the House of Representatives on March 12, 1948, by a divided vote placed this proposal indefinitely upon the table, thus preventing action by the House of Representatives, and

Whereas, more than the required minimum of twenty-six nations have become signatories to the World Health Organization and have thereby established this organization without United States participation, and

Whereas, if the recent action of the Rules Committee stands, the United States will be excluded from official participation in the formulation of world health programs and by its self-exclusion, the United States will deprive the World Health Organization of the considerable part of its necessary funds which were expected from the United States on the assumption that it would become a member thereof, and

Whereas, the World Health Organization has been approved and, to a degree, sponsored by the American Medical Association, the American Public Health Association, and virtually every other national health organization in the United States, therefore be it

Resolved, that The Medical Society of New Jersey record itself as earnestly favoring the adherence of the United States to the World Health Organization of the United Nations in the interest of promoting world peace, the advancement of health standards throughout the world, and the enhancement of the welfare of the United States, as well as all the United Nations; and be it further

Resolved, that The Medical Society of New Jersey urgently petition the Rules Committee of the House of Representatives to place the favorable report on the World Health Organization of the Committee on Foreign Relations on the calendar for earliest possible action by the House of Representatives; and be it further

Resolved, that copies of this resolution be transmitted to each member of the Rules Committee, the Speaker and majority leader of the House of Representatives, the members of the House from the state of New Jersey, and the President of the United States.

PRESIDENT SCHAAF: This resolution, also coming from the Board of Trustees, will be referred to the Reference Committee on Resolutions and Memorials.

MR. BRYAN: The following resolution relates to Senate Bill 148 for county and part-county health units.

Whereas, the platform of the American Medical Association, adopted in June, 1944, declared in part: "There is great need for the increase of county or district departments of health . . . . Every area in the United States should have a health service with adequate personnel and facilities . . . . It should be integrated with and coordinated by the state health department," and

Whereas, Chapter 177 of the Laws of 1947, State of New Jersey, reorganized the State Department of Health and conferred upon it the authority to

> "Require local boards of health to establish and maintain a program of recognized public health activities and to meet minimum standards of performance as prescribed by the Public Health Council . . . ." and

Whereas, it is impossible for any central authority to require any but a few of the 566 local boards of health to "establish and maintain a program of recognized public health activities" as long as the majority of these local health districts have populations of less than 2,500 each to support their local health services, and

Whereas, health and medical authorities have unanimously approved pending Senate Bill 148 to enable local communities in the fourteen smaller counties to combine their health services in county or part-county health departments, therefore be it

Resolved, that The Medical Society of New Jersey hereby urgently request the Legislature and Governor to enact S-148, as an essential step in providing modern high quality health protection to the people of New Jersey.

PRESIDENT SCHAAF: This resolution has been acted upon by the Trustees and will go to the Reference Committee on Resolutions and Memorials.

MR. BRYAN: The following is a resolution regarding a survey committee on a Medical School in New Jersey.

Whereas, the standards of medical practice, and consequently, the health level of a community are elevated by the existence of an approved medical school in the area in which it serves, and

Whereas, there is at present no medical school in New Jersey, and

Whereas, collegiate educational facilities of all kinds, except in medicine and dentistry, are available to the people of this state, and

Whereas, many physicians, educators, and influential members of the lay public have long believed that a medical school is needed in New Jersey, and

Whereas, unless new or additional facilities are developed for the education of a large number of physicians there may be a serious shortage of medical personnel by 1960, and

Whereas, the State University at Rutgers is at the present time expanding existing and adding new facilities for collegiate education and is considering general aspects of the problem of establishing a medical school, and

Whereas, a high grade medical school can be developed only with wholehearted cooperation on the part of the medical profession in the area in which it is to be established, and

Whereas, the Board of Trustees of The Medical Society of New Jersey has endorsed the principle of an approved medical school under university auspices and supported by general tax funds, therefore be it

Resolved, that The Medical Society of New Jersey offer to assume leadership in the study of all matters relating to the need for, the development and the operation of an approved medical school and be it further

Resolved, that The Medical Society hereby propose the establishment of a representative study committee to be composed of sixteen members to be appointed as follows: (1) that The Medical Society designate four of its members; (2) that The Medical Society invite Rutgers University to appoint four additional members; and (3) that The Medical Society request the Governor of New Jersey to appoint eight additional members from among leading lay citizens, and be it further

Resolved, that this survey committee be commissioned to investigate and study the requirements for successful completion of this project, and, upon completion of its study, it shall make known its recommendations to the Governor and the Legislature.

PRESIDENT SCHAAF: This proposed resolution, coming from the Trustees, will be referred to the Reference Committee on Resolutions and Memorials.

MR. BRYAN: The following communication from Courtney H. Hodges, General, United States Army is addressed to Dr. Schaaf, March 29.

Dear Dr. Schaaf:

In connection with the current urgent shortage of physicians, dentists, and nurses in the military service, I feel it desirable to request the advice and assistance of the many doctors who are members of Army Advisory Committees.

Complete staffing of medical installations in my command at this time would require 207 Medical Corps officers in the various grades and specialties to carry the heavy work load; we are now below that strength. Furthermore, we expect to lose by separation before 30 June 1948 approximately 95 officers, with no prospect of substantial replacement. The situation with respect to dentists and nurses is similar.

You will appreciate the strain on morale incident to the overwork, extra duty hours, and disruption of hospital and dispensary procedures, all traceable to the shortage in trained medical personnel.

The First Army Surgeon is bringing this problem to the attention of the various medical societies and organizations in this Area. You will undoubtedly be asked to cooperate in the general effort.

Beyond that general effort, I would greatly appreciate your advice on a personal basis. I think you will agree that in the last analysis the solution of the problem must rest on obtaining those individuals in the medical professions who for one reason or another are at this time interested in either a temporary or permanent tour of duty with the Army. There may well be, within your professional acquaintance, some physicians, dentists, and nurses whom you could recommend with confidence in their ability, and who might desire service in the Medical Corps of the Army.

I ask you to consider this problem as within your special field of interest. I shall later bring the situation to the attention of the Army Advisory Committee as a whole. I wanted, however, to have the benefit of your early counsel.

I ask it on the ground that the standards of the Medical Corps can be maintained only by obtaining highly qualified personnel in adequate numbers. I ask it in the conviction that the overall efficiency of the Armed Services is a matter which must fundamentally concern every loyal citizen in these troubled times.

Sincerely yours,

COURTNEY H. HODGES,
General, U. S. Army.

PRESIDENT SCHAAF: Since this relates to military service, it will be referred to Reference Committee C, which is to consider the report of the Military Service Committee.

MR. BRYAN: Here is a communication from the Council on Medical Service, American Medical Association, dated April 21, 1948.

AMERICAN MEDICAL ASSOCIATION
Council on Medical Service
535 North Dearborn Street
Chicago 10

April 21, 1948.

Dear Dr. Schaaf:

The recent meeting in Los Angeles of A.M.C.P. and Blue Cross Commissions, a convention of directors and trustees of medical and hospital plans, provoked an unusual amount of talk for and against a national enrollment policy and a national organization composed chiefly of directors and trustees of A.M.C.P. and Blue Cross groups which would develop a national insurance company designed primarily to insure nationally employed groups.

Since the meeting, the Council on Medical Service of the A.M.A. has been approached and urged to obtain an expression from representative doctors in the various states who are in the active practice of medicine concerning the proposals and resolutions adopted at the joint conference of A.M.C.P. and Blue Cross delegates.

Therefore, the Council on Medical Service believes it is imperative that the president of each state society or the chairman of the Council of each state society or someone designated by the executive family of each state organization convene in conference in order to obtain the *sentiment of practicing physicians and surgeons* in their respective states relative to the *proposed merger of A.M.C.P.* and *Blue Cross* and the development of a *national insurance company.*

Sincerely yours,
THOMAS A. HENDRICKS, Secretary
By order of the Council
on Medical Service.

PRESIDENT SCHAAF: Reference Committee C will consider the reports of the Medical Service Administration and the Medical-Surgical Plan, and this matter will therefore be referred to Reference Committee C.

MR. BRYAN: The following resolution calls for a change in the By-Laws, Chapter VIII, Section 2.

"That the By-Laws be amended as follows:

"(1) Chapter VIII, Section 2, Standing Committees:
Delete the words 'Post-Graduate Education Committee' and substitute the words 'Committee on Medical Education'.

"(2) Chapter VIII, Section 11:
Delete the present title 'Committee on Post-Graduate Education' and substitute the title 'Committee on Medical Education'.

"(3) Chapter VIII, Section 11, first sentence:
Delete the words 'Committee on Post-Graduate Education' and substitute the words 'Committee on Medical Education'."

PRESIDENT SCHAAF: This proposed change in the By-Laws, as read at this meeting, will be referred to the Reference Committee on Constitution and By-Laws; and if approved at the final meeting of the House of Delegates on Thursday, it will become effective at once.

MR. BRYAN: Here is another proposed amendment to the By-Laws relating to Chapter VIII, Section 10.

AMENDMENT TO BY-LAWS
Chapter VIII, Section 10

Amend section by changing words "The Welfare Committee shall consist of thirty-five members" to "The Welfare Committee shall consist of not more than sixty members, exclusive of consultants".

Amend same section by changing words "Special Advisory Committees, of five members each" to "Special Advisory Committees of not more than fifteen members each".

PRESIDENT SCHAAF: This proposed change in the By-Laws having been read here, will go to the Reference Committee on Constitution and By-Laws, and if approved at the meeting on April 29, it will become effective at once.

MR. BRYAN: The secretary of the Essex County Medical Society has questioned the standards used by the Crippled Children Commission in determining what doctors are permitted to request prosthetic appliances for clients of that commission. The Trustees had this investigated and found that a doctor must be a diplomate of the American Board of Orthopedic Surgery before the Crippled Children Commission will approve his request for prosthetic appliances to be bought by state or federal funds. This is said to be because of a federal ruling governing the use of federal funds made available to the Commission.

PRESIDENT SCHAAF: This will be referred to Reference Committee E.

MR. BRYAN: The Trustees recommend that our delegates to the American Medical Association be instructed to reaffirm our position with reference to increased fees for life insurance examinations, and to introduce at the next A.M.A. convention such other resolutions as they see fit to further this project.

PRESIDENT SCHAAF: No resolution on this was forwarded with the communication, so a motion would be in order for a committee to draft an appropriate resolution and refer it to the Resolutions Committee for consideration.

(Motion was made and carried.)

MR. BRYAN: The Board of Trustees endorses the supplemental report of the Medical-Surgical Plan of New Jersey and requests this endorsement be made known to Reference Committee C, to which the report is referred.

PRESIDENT SCHAAF: This supplemental report of the Medical-Surgical Plan is a very important one which should be freely discussed by the House of Delegates, and I am going to call on Dr. Scott first to present it.

DR. SCOTT: Mr. President and Members of the House of Delegates: I respectfully request that you give close attention and due consideration to the supplemental report of the Medical-Surgical Plan which you have received.

In the first section we have tried to depict to you the experience of the Plan by periods, from our experience of the first six months, when we covered an enrollment of 4,000 per-

sons and had an earned income of $11,000, to the twelve-month period ending March 31, 1948, when we covered 162,000 persons with an income of one million dollars.

Our growth was slow during our early experience, intentionally so, while we proved our actuarial determination. Later, our growth has been more rapid but not as rapid as we would wish.

Administrative costs have been gradually reduced from 51 per cent during the first six months' period to 16.5 per cent during the past year. For the first three months of 1948 our administrative cost was 15.4 per cent, and we hope by new administrative technics, soon to be introduced to reduce that cost materially.

Our financial statement as of March 31 shows total assets of about one-half million dollars, of which $327,000 is in reserve. Of that reserve about $250,000 is invested in government bonds. I think that depicts the healthy financial situation of the Plan. The Plan, in fact, has never been in financial difficulty.

The basic fact shown in this report is that the medical care distribution problem [in so far as that involves the care of catastrophic illness] can be solved on the pre-payment insurance basis.

As of December 31, 1947, Associated Medical Care Plans, reported on 67 non-profit medical care plans, each organized by a unit of organized medicine. Of these 67 plans, 53 are affiliated with Blue Cross Plans. The Council on Medical Care of the American Medical Association has approved 60 of these Plans. The Plans operate in 42 states. Plans in the six remaining states are in an organization phase. Total enrollment in these Plans as of December 31, 1947, was 7,328,143 persons.

Attention is called to the items from the fee schedule which represent the most common services rendered, which comprise about eighty per cent of our claim costs and were the items used in computing our new actuarial determination. They are gauged to meet the prevailing fees in New Jersey.

For medical cases (not surgical) services rendered to a bed patient in hospital up to 21 days during any contract year: first call from $5. to $10., subsequent daily calls from $3. to $4.

Now, perhaps that $10. for the first visit is higher than the prevailing fees in New Jersey. The Plan always aims to operate within our present framework of medical practice, but we recognize one defect within that framework and that is the discrepancy in income between the internists or general practitioner rendering medical care and the surgeon rendering surgical care.

If the average patient admitted to a hospital is given the care necessary during that first day of hospitalization and the attention that is required during that first day, then the services are worth $10, particularly if proper notations are made on the patient's history.

It will help equalize our fees paid to physicians in the serious type of case admitted to hospital, such as the coronary, the diabetic coma, uremic patient, which requires a lot of attention the first day. It will increase our payments for the twenty-one days' medical care from $65 to $92; under surgical fees, appendectomy, from $100 to $150; gall bladder removal, from $125 to $200, and so forth.

I would like to comment on the obstetrical benefit. The accomplished obstetrician cannot cater to persons who provide payment of a $50 obstetrical fee. We therefore raised our payment for a normal delivery in a hospital to $75, with $100 for low forceps and $125 for mid forceps.

It has been suggested that perhaps we could pay $100 for all deliveries regardless of the type. It's also suggested that we pay $100 for any operative delivery regardless of type. That would be of advantage to us actuarially, but medical care is not always rendered actuarially. It becomes a very individual, personal problem, this rendering of obstetrical care. The patient and the physician expect more income on the individual case basis for the difficult case and we would like to make our operative obstetrical fees sufficiently high to attract the accomplished physician, the accomplished obstetrician because we know that a mid forceps delivery, for instance, is a formidable procedure which should be undertaken only by an accomplished obstetrician.

I would like to add my own appreciation and thanks for the sincere cooperation we have had from this House of Delegates and from our participating physicians. It renews one's faith in the integrity of the medical profession and the ability of the medical profession to solve this problem. Thank you.

PRESIDENT SCHAAF: Thank you, Dr. Scott. The president of the Medical-Surgical Plan is here and I invite Dr. Lewis to add something to this discussion.

DR. LEWIS: I have nothing to add, Mr. President, except that I feel that this is a most important matter and requires careful consideration by the House.

PRESIDENT SCHAAF: The essence of the report is that there is a proposal to increase the premium rates, to increase the benefits payable

under these policies, and to raise the income level across the board to $5,000. Now, that is the essence of the report and it is debatable, but before referring this to the Reference Committee, I would like to have Mr. Sorg, who is president of the Hospital Plan and who is thoroughly familiar with the actuarial data connected with this proposal and who directs the sale of the Medical-Surgical Plan policies, present the matter to this House of Delegates for your consideration.

Mr. Sorg: I think it is a fine thing that you have invited the Hospital Service Plan to contribute its views to the question raised by this report of the Medical-Surgical Plan. It is quite appropriate that after five years of association both the Hospital Plan and the Medical Plan should render an account of their stewardship to the House of Delegates.

While it is true that the Medical Plan and the Hospital Plan have been associated only for five years, it must be remembered that the medical profession has been associated with the Hospital Plan since its inception in 1932. It seems almost unbelievable that the Hospital Plan should have existed for only sixteen years. Actually, the Hospital Service Plan of New Jersey was the first Blue Cross Plan in the United States. All the ninety-one Plans in the country today are patterned, to some degree or other, after the New Jersey Plan. It is true that there was a hospital in Dallas, Texas, which had the idea of a pre-payment plan for school teachers. We are indebted to that hospital for the idea which our Hospital Council in Essex County utilized to create the Hospital Service Plan of New Jersey.

At the time it was created there were two problems of major importance that confronted our Hospital Plan. The first was necessarily the cooperation of the hospitals. We were not too much concerned about that because practically every hospital in the country in 1932 was in the red and they didn't care very much from what source additional help might come. We had no difficulty in getting their cooperation in providing this new means of meeting hospital bills. However, we also needed the cooperation of the medical profession because without that cooperation there never would have been a Hospital Plan. There was some degree of suspicion originally on the part of the medical profession. It was an entirely new idea, this mutual cooperative plan of multiple hospitals associating together and forming the Hospital Plan, and it was understandable that there should be in the minds of some doctors the question of whether it was not a first step in the direction of socialized medicine. Actually, it probably was the wisest step that was ever taken because in the recent debates before the Congressional committees the strongest point that the physicians raised against the federal plan for socialized medicine was the fact that there were in existence these hospital and medical-surgical plans all over the country prepared, on a non-profit basis, to render the very service which the government thought was needed.

It could not have been done without the cooperation of the medical profession in this state and it was not done without their cooperation. We sat up many a night and discussed it with groups of doctors in order to enlist their help in getting it started. In a very real sense, The Medical Society of New Jersey not only was present but actually rendered obstetrical services at the birth of the Hospital Service Plan in 1932.

After we had had ten years' experience with the Hospital Plan there came along the Medical-Surgical Plan. Three years prior to the time that we became associated in marketing the subscription contracts of the Medical-Surgical Plan there had been studies made by the medical profession which had demonstrated the need of such a plan. In these studies, our Hospital Plan had no part. When it was first suggested that the Hospital Plan should handle the mechanical details of marketing the contracts of the Medical Plan and of keeping their accounts and records, we demurred because we were afraid it might interfere with our own program. We were very busy with our project and we still are, and we were afraid that the injection of this new contract into the situation might be a hindrance. It meant that when we went to an employer or to an employee group we had to sell twice as much as we had been selling before because the cost of the two contracts was just double what ours at that time cost.

However, on our Hospital Plan Board there were a number of doctors. There still are. We have six physicians on our Hospital Plan Board of Trustees at the present time: Dr. Sprague, Dr. Guion, Dr. Murray, Dr. Lewis, Dr. Ward and Dr. Londrigan, and they are very active members, too. At first we were reluctant to take on this new medical plan venture but there were one or two of your doctor members, particularly Dr. Sprague, who kept insisting that it would be a good thing for the Hospital Plan as well as the Medical-Surgical Plan. This was worked on for two or three years and by 1942 we had succumbed and we were ready to go to work.

In getting up the subscription contract form

there was the question of how it should be approached. It was desirable that the terms of the two contracts be as nearly alike as possible. You have no idea the amount of difficulty there is in presenting for sale to large groups of individuals the matter of contracts and explaining their terms.

A contract is never prepared for the lay person to understand, but rather that a court and another lawyer can understand it, because ultimately it goes to court and the validity of the contract and its value is determined eventually in terms of legal construction. Thus, there may be some difficulty for a layman who is reading a subscription contract to understand just what it means. I doubt, however, whether it is any more difficult than for a layman to understand a doctor's prescription which is given him; and you understand, of course, there too that when you write out a prescription it isn't for the layman to understand but it is for the pharmacist to understand.

Ever since our organization of the Hospital Plan, The Medical Society of New Jersey and the Essex County Medical Society nominate annually a member to our Board and I think that cements the relationships. We have been very fortunate in that.

In connection with the Medical-Surgical Plan, the medical profession really outdid itself in setting up the kind of board and government that it has for that Plan. You have on that board some of the ablest men in any line of profession or business and they give unlimitedly of their time and energy to it. During the past five years, there has never been one time when there hasn't been complete understanding betwen the two groups. They have always been receptive to recommendations which would advance the program and we have been receptive to any suggestions on their part which would expedite it.

You are extraordinarily fortunate in having Mr. Thompson on the board of the Medical-Surgical Plan. He is the only layman on that board. He is one of the outstanding actuaries of the United States; he is president of the Mutual Benefit Life Insurance Company, and for many years has had that insurance background, which has proved of invaluable aid to your organization. And, in Dr. Scott you probably have the outstanding medical plan director in the United States today; so much so that constantly his advice and services are being sought for in other parts of the country.

Originally, the question whether or not the services of the physician were inclusive under your Plan contract was determined by the nature of the hospital accommodation utilized by the patient. In our Hospital Plan contract, services are inclusive when they are rendered in either ward or semi-private accommodations, and therefore we followed the same pattern in that with respect to the Medical-Surgical Plan. A year or so later we introduced the salary limitation, which is now, for a family, $2500. Today, the Medical-Surgical Plan is proposing to make that $5000. This $2500 ceiling has hampered us in making sales because today a group in the Medical-Surgical Plan is almost never enrolled unless the employer contributes part of the cost.

In our Hospital Plan at the present time we have something like 4000 groups enrolled. Of those 4000 groups there are 700 in which the employer pays either all or part of the subscription rate of the employee.

When it comes to the Medical-Surgical Plan you are loading on to what the employee is already paying [in a great many instances his hospitalization cost runs up to $2.60 a month] an additional amount for medical-surgical coverage, and that means that he is paying a little over $5.00 for more than two in a family, $5.60 per month for his coverage in both plans. That is a burden on many lower salaried employees. However, we may as well recognize that today more and more the cost of carrying both the Hospital Plan coverage and the Medical Plan coverage is going to be borne by the employer, which in my own individual opinion—not speaking now as Plan president—is where it belongs.

We have on our Hospital Plan board representatives of the two large labor organizations in the country, the CIO and the American Federation of Labor. Each nominates a member to our board annually. They concur in what I am saying, that in the last five years there has been an acceleration of that trend toward having the employer carry the load. You may say that's too much to expect of the employer, and, maybe at first blush one would get that impression; but let me point this out to you: only twenty-five years ago, the Workmen's Compensation Law went into effect and New Jersey was one of the early states to adopt it. Before that, the employee had little protection. He took a chance. If he was injured during the course of his employment, he could sue his employer if he was solvent and the employer had all manner of legal objections and defenses to any claim. When the Workmen's Compensation Act was introduced, it had the proviso that the employer pay the cost of it. Industry generally took the attitude that socialization had now come and the day of individual effort as we have it here in this country was a thing of the past. They

thought it was the end. Today the Workmen's Compensation premium is paid as a matter of course by every employer and there isn't even the slightest thought on the part of anyone that it is socializing industry.

Within the foreseeable future, within the average lifetime of those of us who are here, that same thing is going to occur with regard to both the Hospital Plan and the Medical Plan. As I say, in the Hospital Plan 700 employers already have seen the light voluntarily.

A new development has arisen in the last year, the problem of enrolling national organizations. There has been difficulty in getting a national group to enroll their employees in ninety-one different hospital plans. You go to a national employer and say: "Now, we have an idea of selling you a Blue Cross contract." He says, "I have employees all over the country." Well, here are ninety-one contracts, every one of which is different in costs, in benefits, in provisions, and he says, "Never mind." That has been the actual experience.

If you were to say in addition to that: "Well, now, after you have looked at the ninety-one we also have forty-odd medical plans; we can give you forty-odd companies there too;" he won't do it. He will say: "I'd rather go to one of the commercial companies that gives me one contract."

There are two ways of meeting that situation, one of which is a menace to our Hospital Plan, to the Medical Plan, and to the medical profession. That is this new proposed national federation of Medical and Blue Cross Hospital Plans into one organization to sell on a national basis, primarily intended to sell to national groups. If this Medical Society becomes a part of any such organization, [in which it would have only a very minute representation], it is the beginning of the end for your independence. I personally would rather take a chance with a government program than I would with such a program of individuals where perhaps there are only a half dozen doctors against three dozen laymen on a Board which would control both the medical-surgical and the hospital coverage. I have advised our Plan and I have also advised the Medical-Surgical Plan that it is illegal for us, under the laws of this state, to become part of such a program.

I hope that across the country, not many Medical-Surgical Plans or Hospital Plans will become involved in that because I predict that it may mean the ruin of the individual plan.

There is another way of handling it and we have been handling it on that basis. Where the local organization has branches throughout the country we tell them that we will enroll in our Plan all their employees anywhere. Thus, for example, we have some employees of one of our organizations enrolled who are located in Venezuela. We have no trouble with it because our Hospital Plan is set up on an actuarially sound basis and it make no difference to us whether the man lives in Timbuctoo or in Jersey City. We are even now negotiating with one group which has a New Jersey affiliation, the total group numbering 150,000. Their Executive Committee has recommended that they enroll in the Hospital Plan of New Jersey.

We have twenty national organizations presently enrolled in the Hospital Plan, such as Ballantine and a few others, some equally prominent; they have employees across the country, and we have never had any difficulty in administering, for two reasons: One, our Hospital Plan pays very high benefits. There is no plan in the United States which pays higher benefits than our Hospital Plan in New Jersey. Second, we do in New Jersey what only about eighteen of the ninety-one hospital plans in this country do: We pay as much money to a hospital if a person is hospitalized in Los Angeles or Hawaii or in Europe as we would if that person were hospitalized in New Jersey. Well, you say, that's simple; that ought to be done. But only eighteen of the hospital plans do it; the others pay, some of them, as little as one-half, if a man is hospitalized outside of the state in which the plan is located. That is unfair to the subscriber.

If you belong to our Hospital Plan and were up in Maine in the summer and broke your leg and went to a hospital there, there is no good reason why only half of your hospital bill should be paid, whereas the whole bill would be paid if you were in New Jersey.

If we are going to get those national groups enrolled in the Hospital Plan we want to also offer them the coverage that you have available.

Your total enrollment all over the country, is about seven million as against thirty million enrolled in the Hospital Plans. In other words, your total enrollment is about 25 per cent of that of the Hospital Plans all over the country; but in New Jersey it is only about 14 per cent of the number enrolled in the Hospital Plan of New Jersey.

The difficulty we have been meeting with is twofold: The employer says: "Now, you have a salary limitation of $2500. That doesn't help my employees because the cost of living today has gone up so that this is no longer a realistic salary limitation."

One of the largest industries in New Jersey, which numbers over 20,000 persons and which

we have enrolled in our Hospital Plan, has consistently refused to enroll in the Medical-Surgical Plan with that low salary limitation.

Our Hospital Plan has never trespassed on the prerogatives of the Medical-Surgical Plan or in its relations with its physicians. There is one thing, however, to which I must plead guilty. We have consistently urged that the payments to the physicians must be raised as quickly as possible and we believe that the success of your Medical-Surgical Plan can be attained only if you make those payments to physicians realistic. We are glad that the Medical-Surgical Plan trustees have unanimously concurred in the idea of a higher salary limitation and increased fees to physicians, and they have also unanimously concurred in the third thing, which is absolutely essential: a higher subscription rate.

One question sometimes asked is this: If you have a rate of three dollars for a family to be enrolled in the Medical-Surgical Plan, can an indigent person afford three dollars a month coverage?

The answer is, the real indigent won't pay it anyway, whether it's a dollar or two dollars or three dollars. We have had persons in groups tell us: "If I'm sick I can go to a hospital and be taken care of and I never have paid a doctor bill in my life," and so forth.

It is the experience of Mr. Durgom, it is my experience, it is the experience of our Plan over sixteen years that the only true way of taking care of the employee, (so-called medical indigent as distinguished from the indigent who has no employment), is for the employer to contribute or pay all of the subscription rate, and the unions realize that, too.

In Newark right now there is a strike going on because the employees are insisting that as part of the new program with their employer there shall be provided the cost of hospitalization and medical coverage.

You can see why an employer is receptive to the idea of paying for the coverage in the two Plans. When he pays out a dollar for the coverage, the government pays part of it because it is deductible as part of his operating expense. In my opinion, that is the true way for the government to participate in coverage and still maintain the independence of the physician and of the individual.

If this new program is ratified by the House of Delegates, I believe that within several years you will have a half million enrolled in your Medical-Surgical Plan instead of 160,000; and in the not distant future, a million.

Realize what that means: one-quarter of the population! We look forward, within the not distant future to having one-half of the population enrolled in our Hospital Plan. When that day comes it is going to mark an advanced step in the proper care of individuals in hospitals and ultimately also in their medical care.

So far as the Hospital Plan is concerned, we shall never encroach upon the prerogatives of the Medical-Surgical Plan; and so far as I am concerned we shall continue to welcome the association which has been a delightful one for us during the past five years. Thank you.

PRESIDENT SCHAAF: Thank you very much, Mr. Sorg. We appreciate your coming. The Board of Trustees endorsed the supplemental report of the Medical-Surgical Plan of New Jersey and requests that this endorsement be made known to Reference Committee C, to which the report is referred.

DR. NEWCOMB: Does the Medical Plan include tuberculosis?

DR. SCOTT: For the twenty-one days of medical care which we provide.

DR. NEWCOMB: What does it include for any other disease?

DR. SCOTT: Twenty-one days. When we started this Plan we had no restriction on the number of medical days, but we had many examples of patients going in the hospital, and remaining there week after week, without any disease requiring hospitalization.

We studied the matter and found that more than ninety-five per cent of our cases were hospitalized less than twenty-one days; to prevent abuse by that five per cent or perhaps one or two per cent from using our subscription money for services considered ineligible, we put that twenty-one days' limitation on it; and that does cover even at present, ninety-five per cent of the persons.

DR. NEWCOMB: Do you pay less for other days?

DR. SCOTT: No.

DR. NEWCOMB: I had a letter from Dr. Little of the Bergen County Tuberculosis Hospital, saying that they paid so much for 180 days in other diseases.

DR. SCOTT: The Hospital Plan will do that. After twenty-one days, they pay $3.50 a day for the 180 additional days for eligible conditions.

DR. NEWCOMB: Why not include tuberculosis, which is a long drawn out disease when some other surgical cases are rather short?

MR. SORG: No hospital plan could stand up if there was an unlimited number of days for chronic ailments. It is far better for us to

take care of ninety-five per cent of the population than to wreck the whole Plan trying to take care of the five per cent.

I know of no rate of subscription payment which could take care of an unlimited coverage for chronic cases. It would take only a thousand or two of such cases out of a million to wipe out your surplus.

PRESIDENT SCHAAF: We now proceed to the next order of business, which is to continue the Trustees' report.

MR. BRYAN: Following is a recommendation of the Welfare Committee regarding medical attention at construction jobs.

An insurance company has asked for the Society's reaction to proposed programs concerning medical attention at construction jobs where the general contractor is insured by their company.

1. Where the construction job is located some distance from the nearest doctor, it is proposed that a first-aid room be established in charge of a registered nurse. The nurse, under the direction of the local doctor, would handle the treatment of injured employees in accordance with *Standing Orders for Nurses in Industry* prepared by The Council on Industrial Health of the A.M.A. She would give such first-aid and emergency treatment as might be necessary. The nurse would treat minor lacerations, etc., and [where directed by the doctor] redress wounds, burns and similar cases.

2. In addition to the employees of the general contractor, there are many employees of sub-contractors. These sub-contractors are anxious to use these first-aid facilities and the services of the nurses for the treatment of their injured workers under the same procedures and the direction of the same local doctor. The local doctor, of course, makes a charge to the sub-contractor for his professional services. We have been asked by the general contractor if there is anything improper in billing the sub-contractors for a proportionate share of the cost of operating the first-aid facilities which average about $2 per treatment or visit.

RECOMMENDATION OF THE MEDICAL PRACTICE COMMITTEE APPROVED BY THE WELFARE COMMITTEE

1. We are in accord with the idea that first-aid service should be available on the job for injured employees.

2. To avoid any semblance of contract practice of medicine, we recommend that the carriers and the contractors arrange with the doctor who is taking care of the carriers' work to set up his own facilities on the job under leasing arrangements to be determined by the doctor and the carriers and sub-contractors. In this way, services can be rendered on the job without going counter to the ethical and legal objection to the corporate practice of medicine. The doctor will operate the clinic and employ the nurses, etc.

PRESIDENT SCHAAF: This is referred to Reference Committee E.

MR. BRYAN: The next matter concerns emeritus memberships. Here are the recommendations of the various counties:

Passaic County: Dr. William Flitcroft, Waukesha, Wisc.; Age 86; Retired because of age; county member, 1891; county emeritus member, 1938; member in good standing; nominated for A.M.A. Affiliate Fellowship.

Atlantic County: Dr. Clara K. Bartlett, Atlantic City; Age 81; Retired because of age; county member, 1901; member in good standing; nominated for A.M.A. Affiliate Fellowship.

Hudson County: Dr. Henry E. Woelfle, West Palm Beach, Fla.; Age 70; Retired because of ill health; county member, 1905; member in good standing; nominated for A.M.A. Affiliate Fellowship.

Dr. J. Phillip Stout, Red Bank, N. J.; Age 57; Retired because of ill health; county member, 1924; member in good standing, nominated for A.M.A. Affiliate Fellowship.

Dr. George H. Sexsmith, Los Angeles, Calif.; Age 88; Retired because of age; county member, 1894; member in good standing; nominated for A.M.A. Affiliate Fellowship.

Dr. Samuel Selinger, Lake Worth, Fla.; Age 55; Retired because of ill health; county member, 1924; member in good standing; nominated for A.M.A. Affiliate Fellowship.

Dr. James H. Rosecrans, Hoboken; Age 90; Retired because of age; county member, 1895; member in good standing; nominated for A.M.A. Affiliate Fellowship.

Dr. Wallace Pyle, Jersey City; Age 71; Retired because of ill health; county member, 1900; member in good standing; nominated for A.M.A. Affiliate Fellowship.

Dr. Benjamin Older, St. Petersburg, Fla.; Age 65; Retired because of ill health; county member, 1911; member in good standing; nominated for A.M.A. Affiliate Fellowship.

Dr. Thomas D. Keegan, Deal Park; Age 68; Retired because of ill health; county member, 1906; member in good standing; nominated for A.M.A. Affiliate Fellowship.

Dr. Hugo Gilie, Jersey City; Age 70; Retired because of ill health; county member, 1903; Member in good standing; nominated for A.M.A. Affiliate Fellowship.

Dr. John Connell, Jersey City; Age 83; Retired because of age; county member, 1910; Member in good standing; nominated for A.M.A. Affiliate Fellowship.

Dr. David R. Atwell, Hoboken; Age 89; Retired because of age; county member, 1908; member in good standing; nominated for A.M.A. Affiliate Fellowship.

PRESIDENT SCHAAF: That will be referred to the Reference Committee on Resolutions as requested by the Trustees.

MR. BRYAN: Here is a resolution which the Board of Trustees recommends be referred to

the proper Reference Committee for consideration.

To improve the working relationship for better school health programs by (1) school administrators, (2) school physicians, (3) nurses, (4) boards of education, and (5) interested health agencies, particularly at local effective levels,

Be it resolved, that The Medical Society of New Jersey request the House of Delegates of the American Medical Association, at their 1948 meeting to direct the Bureau of Health Education of the A.M.A. and the state and county component medical societies, in cooperation with State Departments of Education, Health and other suitable state official and non-official agencies interested in school health, to set up effective state and county "Better School Health Committees" to work for the installation of a modern better school health program in each school system or unit in the United States. operating under permanent local better school health committees in each school system, whose minimum membership should include the school administrator, school physician, school nurse, president and secretary of the local Board of Education, and the president of the local P.-T.A., together with suitable representatives of interested health agencies.

President Schaaf: This will be referred to the Reference Committee on Resolutions and Memorials.

Mr. Bryan: The Board of Trustees recommends that the following resolution be referred to the proper Reference Committee for consideration and recommendation to the House of Delegates:

Whereas, The American Medical Association held the first national school health conference in October, 1947, and included in its third rural health conference in February, 1948, the health and medical care problems of rural children and

Whereas, State and county medical societies, having child health committees and programs, have need of guidance and assistance at national levels for their child health programs by having a specific bureau of the American Medical Association responsible for children.

Therefore Be It Resolved, that The Medical Society of New Jersey request that the House of Delegates of the American Medical Association add the words "Child Health" to the title of the present Bureau of Health Education, to read "The Bureau of Child Health and Health Education", in order that this excellent and helpful bureau may definitely be regarded by county and state medical societies as the coordinating center in the Association for the study and evaluation of the many types of child health and medical care programs being evolved by governmental, medical, and voluntary agencies in this country.

President Schaaf: This will be referred also to Dr. Cosgrove's committee.

Mr. Bryan: This is a communication from Mr. Edward L. Parker, Chairman of the Interim Committee of the New Jersey Housing Council.

On March 13, delegates from a number of civic groups met to discuss the housing shortage. It was unanimously agreed that present conditions were deplorable; that special hardships were involved for middle and low-income groups; and that public grants to help develop low-cost housing were necessary. It was further agreed that unity of planning and action along the following lines was required:—

(1) Support of United States Senate Bill No. 866—the Taft-Ellender-Wagner Bill, calling for federal grants to promote low-cost housing,
(2) Support of principles set forth in New Jersey State Assembly Bills No. 188 and No. 189, calling for a public referendum on a bond issue for low-cost housing.

After these had been adopted unanimously, it was agreed that an Interim Committee should develop further interest and planning on a state level. Among the 26 organizations which expressed interest or support of the above proposals, were: New Jersey State Welfare Council, Board of Christian Relations of the Episcopal Diocese of Newark, various Veterans' organizations, C.I.O., A. F. of L. and Visiting Nurse Associations.

We trust that you will agree with the steps already taken; and further, that your organization will join with us to develop statewide support; and that through proper channels, you will obtain official action; and in any case, see that a delegate represents you there. It is necessary at this time to review steps taken to date and to consider future action.

Very sincerely yours,
Edward L. Parker, Chairman,
Interim Committee of New Jersey
Housing Council.

President Schaaf: This will be assigned to the Reference Committee on Miscellaneous Business, without recommendation.

We will suspend the order of business for a moment for a special event.

At the 1947 session of the American Medical Association it was proposed to honor the most distinguished general practitioner in the country. Candidates were submitted from various parts of the nation and a physician from Denver received the award.

That stimulated interest in an award to a general practitioner in this state and at a meeting of the Board of Trustees last fall the proposal was acted upon favorably and a committee, headed by Dr. Costello, was appointed to canvass the component societies to secure recommendations for this award. They deliberated during the winter, considered a number of candidates, and finally designated a physician from Essex County to be the recipient of this award.

I will ask Dr. Costello to read the citation.

DR. COSTELLO: Mr. President and Members of the House of Delegates: A committee was appointed consisting of Dr. Sica, Dr. Dodd and myself, to survey the material presented in behalf of the candidates for the out-



DR. COSTELLO, DR. SCHAAF, MRS. WOLFE AND DR. WOLFE

standing general practitioner of New Jersey. We had a most arduous task. Suggestions were made by hospital staffs, nurses, physicians, service clubs and lay individuals; this indicates the interest aroused. The fact that so many of our general practitioners have received testimonials of appreciation and respect from these groups should be an inspiration to the medical fraternity of New Jersey.

After a careful analysis of letters and newspaper articles submitted, your committee has unanimously agreed that Dr. J. S. Wolfe of Bloomfield, New Jersey, is the man most fitted to receive the award, and we make this recommendation to you.

To Dr. Jacob S. Wolfe, of Bloomfield, New Jersey, The Medical Society of New Jersey is happy to present this medal in humble recognition of his distinguished service to his patients, his community, his state and his profession. In so doing we honor Dr. Wolfe as an outstanding family physician and a good citizen.

It is my privilege, Dr. Wolfe, to present this medal to you with the best wishes, congratulations, and the appreciation of the honor that you have conferred upon the medical fraternity. You have our best wishes.

DR. WOLFE: Thank you.

(The Delegates arose and applauded.)

PRESIDENT SCHAAF: Dr. Wolfe, on behalf of The Medical Society of New Jersey, I congratulate you. We are proud of the long practice you have had and we are proud of the way in which you have maintained the traditions of the profession. We wish you many years of health, happiness and further usefulness to your community.

DR. WOLFE: Thank you.

PRESIDENT SCHAAF: Now, so often the doctors are congratulated and we forget that it is the women in the family who keep the home fires burning. We would like also now to recognize Mrs. Wolfe. She has been with him all these years and deserves some of the credit.

(The Delegates arose and applauded while a bouquet of flowers was handed to Mrs. Wolfe.)

PRESIDENT SCHAAF: We will return to the regular order of business and consider the reports. The report of the Judicial Council was published on page 173 of the JOURNAL. As there is no supplemental report, this will be referred to Reference Committee A.

The report of the Executive Officer is on page 173 of the April JOURNAL, but Mr. Bryan has a supplemental report which he will present at this time.

MR. BRYAN: Mr. President and Members of the House of Delegates: I am, of course, very conscious of the fact that this is the first time I have had the privilege of addressing the House of Delegates of The Medical Society of New Jersey. I have enjoyed the time that I have had with you so far and I hope that as time goes on you will enjoy having me around.

There is one little correction it is necessary for me to make in the printed report. It says there that I have visited every county society in the state. At the time that that statement was made it was made with the hope that it would be fulfilled by the time it was printed, but unfortunately I have yet to visit Hunterdon County, which I shall do on May 4, at which time that report will become true.

I want to take this opportunity to thank all the officers and the members of the county societies with whom I have had acquaintance so far and whom I have visited, for the friendly way in which you have received me. It certainly has gone far to make this work extremely enjoyable and I think it also contributes to our mutually accomplishing things.

When I came to work with you eight months ago, your Board of Trustees asked me to concentrate on the public relations of your Society. The officer who undertakes to represent you before the public and to operate any public relations program in your name, or who is your representative before the many agencies with whom we deal, who counsels your officers and committees in the formation of programs involving public acceptance or participation—such a man, I am humbly aware, is entrusted with the keeping of your most precious asset; for without a favorable public opinion, without

implicit confidence among the people in your devotion to their welfare, all our other assets are as nothing.

Yours is the most ancient of all state societies. Nor do I know of any other state society that wields a greater influence or plays a more active and persuasive part in the life of the community than does The Medical Society of New Jersey. These facts must be a source of pride and at the same time an unremitting challenge to all of us. Public relations, in my book, is public service.

Your society and its components are well supplied with policies, objectives and purposes. You know what you want to do. You have drawn your blueprints. Innumerable programs of public service have been prepared. The job now is execution. Our task is to make these plans and policies come true.

Your programs for cancer education, for extension of voluntary health insurance, for school health improvement, for heart disease control, for local health department reorganization, to mention only a few of them, have got to be taken off the drafting boards, out of the committee room and put into action. They must come alive in every village and hamlet in the state. They must be carried into every home, every family, not as a newspaper story with a Trenton date line on it but as something that the doctors in our town are doing, something that they want the people to know about, the local P.-T.A., the church, the Rotary Club, to know about and to help them with.

How to do this? As one who earned his spurs in the service of county societies, I am convinced that the answer to our problem, the key to our future success in making the medical society a symbol of public service in the mind of every citizen is through a much closer and more intimate, conscious partnership between the county and the state societies.

Your state society is, after all, only a confederation of county societies. It can reach out and talk to and work with the people on Main Street only through the local doctors, stimulated and prompted by their county societies.

The well laid plans and programs of the state society are mostly paper projects until the county societies take hold of them and carry them out. Therefore, I propose, with your sanction, to multiply our lines of communication and our points of contact with the county societies. This will be done through personal conferences with the newly elected officers of the county societies; through a state-wide conference of county officers, public relations and public health committee chairmen, which we have scheduled for May; through an occasional news-letter directed only to county society officers; through a renewal of the county society visitations in the fall; through the institution of a clipsheet service for county society bulletins, and in other ways.

I think these efforts should help the county society; I am sure that they will help the state society, and I believe that they will produce good public relations of the most substantial sort.

I cannot conclude this supplementary report without expressing before this company my deep appreciation to Dr. Schaaf and his fellow officers for their personal kindness to me and for the confidence you have shown in me. I hope as time goes on to be able fully to justify that confidence.

President Schaaf: Thank you, Mr. Bryan.

The supplemental report together with the original report on page 173 of the April Journal will be referred to Reference Committee A.

The report of the Finance and Budget Committee on page 175 of the April Journal will be referred to Reference Committee B. There is a supplemental report which Dr. Allman will present.

Dr. Allman: The Finance and Budget Committee have now accumulated all the information for the proposed year of 1948-49, and we suggest a budget in the amount of $95,599. This is an increase of only $5000 over last year's budget, approximately five per cent, which isn't much of an increase in consideration of all the work that the Society is doing.

Many of you have not seen as yet the supplement to the Journal, the *Official List* which came out today. In it is an article on the construction and function of The Medical Society of New Jersey by our President, which will give you some insight of the vast workings of the Society.

I don't want any of you to be confused by those astronomical numbers which our Treasurer read off a while ago, something to the effect that we had $144,000 cash on hand. That fools some of you in here because I heard some whistle and somebody said: "What is he going to do with all that money?" Well, he is going to spend all that money on the budget that you approved a year ago. As a matter of fact, he's got about all the money he is going to get for a long, long time.

This budget is for the dues for 1948 and 1949 and that just starts to trickle in next win-

ter and won't all be in for nearly a year, so that all that money that he talked about is going to be spent long before this starts coming in.

For example, we still have the rest of this month and the month of May to run out of that money. That will take about $15,000. Then, of that money that he reported, 7/12 of that is applicable to the dues for the next seven months. That amounts to about $53,000.

Then there must be some reserve set aside for the House Committee. When he is through, instead of having all that money he will have about twenty-six thousand dollars, which isn't much of a reserve for a Society that is doing a hundred thousand dollars' worth of business a year. So that we need more money in spite of the fact the Treasurer has some money now. That is all going to be spent before this starts to come in.

We recommend, therefore, a budget for 1948, as follows:

PROPOSED BUDGET FOR 1948-49

ADMINISTRATIVE:	
A- 1—Executive Salaries	$33,000.00
A- 2—Staff Salaries	12,500.00
A- 3—Executive Office Expenses	2,000.00
A- 4—Executive Travel	2,500.00
A- 5—House Maintenance	6,000.00
Library	100.00
A- 6—Treasurer	200.00
A- 7—Finance and Budget Committee	150.00
A- 9—Audit	400.00
A-10—Secretary	2,500.00
A-11—Salary Taxes	675.00
A-12—Insurance	400.00
JOURNAL:	
B- 2—Cuts	100.00
B- 5—Journal Office Expenses	500.00
B- 6—Journal Travel	200.00
WELFARE:	
C- 2—Welfare Committee	800.00
C- 3—Legislative Committee	4,000.00
C- 4—Public Health Committee	1,000.00
Public Health Week	1,500.00
C- 5—Public Relations Committee	11,224.00
C- 6—Medical Practice Committee	700.00
SPECIAL:	
D- 1—President	2,000.00
D- 2—A.M.A. Delegates	1,500.00
D- 3—Dues and Contributions	950.00
D- 4—New Jersey Health Congress	600.00
D- 5—Fall Clinical Conference	1,000.00
D- 8—Woman's Auxiliary	3,000.00
D-13—Post Graduate Education Committee	100.00
D-15—Veterans Liaison Committee	500.00
CONTINGENT:	
E- 1—Board of Trustees	500.00
E- 2—Special Contingencies	2,500.00
LEGAL:	
F- —Legal	1,000.00
PENSION:	
H- —Pension	1,500.00
	$95,599.00

DR. ALLMAN: On the basis of that budget, with the membership that we now have, it will be necessary for us to raise that money, of course, from dues, and by simple arithmetic we find that will necessitate the assessment for the coming year of twenty-three dollars per member, and your committee, Mr. President, recommends that.

PRESIDENT SCHAAF: The supplemental report of the Finance and Budget Committee will be referred, together with the original report on page 175 of the April JOURNAL, to Reference Committee B.

Report of the Publication Committee, page 178 of the April JOURNAL, will be referred to Reference Committee B. There is no supplemental report.

The report of the Committee on Medical Defense and Insurance appears on page 176 of the April JOURNAL. The secretary will read the supplemental report.

SECRETARY WOOD: Our state wide open enrollment campaign for accident and health insurance conducted by the National Casualty Company was very successful. We had on February 20, 1948, exactly 2175 policyholders in The Medical Society of New Jersey. By March 22, new applications were received from 503 doctors making a total of 2678 now insured, approximately a 25 per cent increase during the past year. These policyholders were divided as follows, showing the number of contracts in relation to the amount of monthly benefit:

$100	$150	$200	$225	$300	$400	Total
284	134	1304	94	482	380	2678

The results of the campaign among existing policyholders, viz; policyholders before the enrollment campaign opened are shown herewith:

Applications received for increase of coverage	Issued as applied for	Number average	Increase denied to
326	291	18	17

PROFESSIONAL LIABILITY INSURANCE

To date 3855 policies have been issued which represents 85 per cent of our total membership now covered under the special medical defense plan. This is a very creditable record when one considers the substantial number of physicians, who through age and type of employment, etc., do not find it necessary to carry this protection. A study of the statistical report furnished by the insurance company presents the following facts: Losses paid during the year were $37,706; expenses on cases,

attorneys, witnesses, etc. $4013. There were 55 claims reported, against which the company's reserve on those in suit amounts to $31,050. Still held in reserve on old unsettled cases prior to March 1947, amounts to $91,200. Of this amount, $47,000 represents reserves of five cases in suit and in addition one claim settled for $2500, all of which were the result of administering spinal anesthesia. Due to the fact that this is a new kind of claim, your Committee feels that it is too early to make recommendations to safeguard the profession against such losses. Should this trend continue, it is possible that physicians utilizing this type of anesthesia will be placed in the "special hazard group". Such is now applying to x-ray, radium and office tonsillectomies, all of which are subject to an increased rating. Definite action in that direction will be withheld until the outcome of the cases in suit is known and our loss experience established. The Committee were also of the opinion that it was beyond their field of activity to stipulate standards or regulations for the conduct of spinal anesthesia, but it should be emphasized to the doctors, particularly those on hospital staffs and to those who choose to use this type of anesthesia, that from an insurance standpoint our loss ratio may be materially affected.

The Committee would further report that our broker has received requests for insurance on residents and interns employed by hospitals, who are not members of our State Society and therefore not eligible for coverage under the special contract. We are presenting this information to the profession at large with the hope that they will urge all hospitals employing residents and interns to protect them by liability insurance, in order that their private resources may not be jeopardized.

Suits arising from x-ray therapy have been based on the fact that patients are not aware of the possibilities of burns or other potential damage accompanying these treatments. We offer for consideration the feasibility of having such patients sign a form which has been prepared by your Committee, acknowledging the risks involved. This would eliminate the major factor in the occurrence of losses in this field. Should it have the result of bringing about an improvement in the experience of x-ray claims, we could then take steps to reduce the surcharge of 100 per cent exacted by the insurance company and ultimately remove them from the "extra hazard" group.

Your Committee notes with satisfaction the appointment of county insurance committees in many of our large counties. We would urge those county societies having small membership to utilize the district's Judicial Councilor for this service. Through the cooperation of the county group, responsive to their suggestions and criticisms, we hope to maintain a uniform policy throughout the state.

RECOMMENDATIONS

1. Renewal of the professional liability contract with the U. S. Fidelity & Guaranty Company through the Official Broker, Faulhaber & Heard, Inc., Newark, whose offices maintain all records of communications and transactions for the Committee.

2. Renewal of the Accident and Health contract with the National Casualty Company through E. & W. Blanksteen.

PRESIDENT SCHAAF: This report, along with the original report appearing on page 176 of the April JOURNAL, will be referred to Reference Committee D. We now call on Dr. Hawkes for the Honorary Membership Committee report.

DR. HAWKES: The Honorary Membership Committee, consisting of Drs. Hollinshed, Snedecor and myself, nominate for honorary membership in The Medical Society of New Jersey, Mr. William H. MacDonald, Chief of the Local Health Division of the New Jersey State Department of Health, in recognition and appreciation of his many years of assistance to and cooperation with our Society.

PRESIDENT SCHAAF: Thank you Dr. Hawkes. This will be referred to the Committee on Resolutions and Memorials.

The report of the Woman's Auxiliary Committee appears on Page 175 of the April JOURNAL. It is referred to Reference Committee D. I will call on Dr. Dodd for a supplemental report.

DR. DODD: In connection with the preparation of the proposed budget for the coming fiscal year, the president-elect of the Woman's Auxiliary outlined a ten-point program for the coming year. This was as follows:

1. To promote well-informed, interested county auxiliaries.

2. To issue a bulletin designed to distribute Auxiliary news and increase interest among doctors' wives.

3. To promote unity and understanding between the county medical societies and representatives of the Auxiliary.

4. To continue to promote an increase in membership until the goal of 100 per cent is reached.

5. To keep alert and well-informed on medical legislation and enactments.

6. To help preserve the high standards of medical practice in the communities.

7. To acquaint every member with *Hygeia* and promote its distribution.

8. To encourage County Auxiliaries to purchase subscriptions to the A.M.A. *Auxiliary Bulletin* with county dues, so each member may have an added interest in the work of the national organization and the state Auxiliary.

9. To hold a second Conference Workshop early this year.

10. To study closely the health needs of each community and cooperate with the county medical societies to improve health conditions.

(a) To continue the work of the Woman's Auxiliary in connection with the School Health Program.
(b) To hold an all day program on rural health and to put into operation an educational program to improve public health in rural communities.

The Committee approved the program and referred it to the Board of Trustees.

At the meeting of the Board of Trustees on March 14, 1948, the program was approved within the limitations of the budget.

This Committee recommends the approval of the action in this matter.

PRESIDENT SCHAAF: The supplemental report will be referred to Reference Committee D. The Graduate Education Committee report, was published on page 177 of the April JOURNAL and will be referred to Reference Committee D. There is no supplemental report. There is also no supplemental report to the Annual Meeting Committee report, which was published on page 178 of the April JOURNAL. This is referred to the Committee on Miscellaneous Business. The report of the Scientific Program Committee, which was published on page 178 of the April JOURNAL, will be referred to the Reference Committee on Miscellaneous Business. Dr. Clarke tells us that there is no supplemental report, and speaking for the Scientific Exhibits Committee, Dr. Yaguda indicates that they have no supplemental report. The Scientific Exhibits Committee report, which was published on page 179 of the April JOURNAL is referred to the Reference Committee on Miscellaneous Business.

The report of the Welfare Committee on page 179 of the April JOURNAL is referred to Reference Committee E. There is no supplemental report. The report of the Subcommittee on Legislation was published on page 180 of the April JOURNAL. This will be referred to Reference Committee E, and I will call on Dr. Burkett for a supplemental report.

DR. BURKETT: Mr. President and Members of the House: I am reading this report because Dr. Pollak, Chairman of the Committee, has been taken ill, and Dr. Quigley is meeting with the Legislature, which opened today.

The most significant and pernicious development toward federalization of medicine is the continuing growth of indiscriminate grants-in-aid to the states. The attitude of The Medical Society of New Jersey toward grants-in-aid for health purposes has been in strict conformity with the platform of the American Medical Association adopted by its House of Delegates in 1944, Section (D), which advocates: "The allotment of such funds as the Congress may make available to any state in *actual need* for the prevention of disease, the promotion of health and the care of the sick *on proof of such need*". (italics ours)

So far as we have been able to ascertain, the first manifestation of the disregard of this basic section (D) of the A.M.A. Platform was made at the hearing on the Hill-Burton Hospital Construction Act, S.191, in March, 1946. This act, like the Taft-Smith-Ball-Donnell bill S.545, goes on the assumption that all states, in varying degrees, are in need of federal financial assistance. As a matter of fact, there are only ten or twelve states—all in the south and southwest—which could demonstrate need of financial assistance from the federal government for health purposes. Notwithstanding this, the representative of the Board of Trustees of the A.M.A., Dr. Sensenich, at the hearing on S.191 declared that it was felt that this measure came within the Platform of the A.M.A.

What happened to the resolution re S.545, the Taft-Smith-Ball-Donnell bill, presented by the New Jersey Delegates to the interim meeting of the House of Delegates held in January of this year is reported in our February 1948 JOURNAL. The excellent editorial "Federal Grants-In-Aid" (which appeared in the February issue) as to the inconsistent attitude of the House of Delegates toward the disposition of these resolutions expresses our position.

In the report of the Subcommittee on Legislation to the Welfare Committee on March 7, 1948, we called attention to a bill introduced February by Senator Saltonstall, the purpose of which is to provide grants-in-aid to the states for improved public health departments in all communities of the states. This bill sets up the now familiar formula of grants-in-aid to all states regardless of need. It would give the Surgeon-General of the Public Health Service almost absolute domination over public health work. The Surgeon-General, among other things, would determine for the states the *"types of health services"* to be rendered. In testimony at a recent hearing on this bill, Dr. Miller, of Connecticut, member of the Board of Trustees of the A.M.A., in an otherwise excellent statement with respect to this measure, failed to voice any objection to the grants-in-aid feature.

A re-reading of the excellent editorial in the February issue of the State JOURNAL will serve to show the dangerous potentialities of *any* bills which provide for the indiscriminate granting of federal aid to the states for health purposes.

If the A.M.A. fails, as it repeatedly has, to conform its position to its own Platform, just where does this leave the individual states in their legislative efforts insofar as federal health legislation is concerned?

As we mentioned in the annual report, the major state legislative concern is the disposition of the various professional licensing boards. S-23 proposes to place the nine professional boards of examiners listed in that report, along with realtors, State Athletic Commission and the State Board of Canvassors, in the Department of State. A hearing was held before the legislative committees of the Senate and of the Assembly on State Government Reorganization on April 13. A well-organized pro-

gram was presented by the New Jersey Council of Professions in strong opposition to S-23 and in support of the proposal for a separate principal department of the State government: a Department of Professional Boards. President Schaaf presented a very forceful statement on behalf of The Medical Society of New Jersey in opposition to this bill.

There have been two hearings on cash sickness benefits plans before committees of the Legislature at which we presented statements. We have opposed the creation of a state-operated cash sickness benefits fund and have taken the general position that we believe the need for cash sickness benefits plans would be met in the normal course of events through the development of private cooperative plans whose growth has been considerably accelerated in the last two or two and a half years. The State administration has strongly advocated a hybrid plan of cash sickness benefits, a state-operated plan plus provision for the continuance of voluntary plans. *If* the Legislature determines some type of legislation is needed, we favor the Loutrel bills (A-315 and A-316), which provide for a *"state-supervised"* plan and avoid a *state-operated* plan. At this time we are rather hopeful that the enthusiasm exhibited earlier in the administration for some type of cash sickness benefits legislation will subside and that we may escape any legislation of this type at this time. Apropos of cash sickness benefits, we are inclined to believe that this subject should be reexamined by the House of Delegates of the A.M.A. and, that, if possible, a *basic policy* be enunciated as to the application of the principles of cash sickness benefits.

Three bills to which we have voiced objections:

A-255—which would have created a Board of Examiners of Medical Technologists, upon which a hearing was held, and

A-359—which would have had the Department of Health establish health clinics throughout the State, and

A-372—which provided for the establishment of a cancer center under the Department of Institutions and Agencies,

upon recommendation of the Steering Committee, were all transferred, to the Committee on Miscellaneous business, which means, of course, that they are most likely dead for the session.

A bill sponsored by the New Jersey Optometric Society is engaging major attention at the moment. Representatives of the optometrists and the Advisory Committee on Conservation of Vision, and, more lately, the Committee on Legislation, had been endeavoring to resolve objections to this bill. Without previous announcement to us, a committee substitute for the original was reported out of committee and pressed to final passage in the Senate. Fortunately, the legislative recess has given us an opportunity to make strong representations against this bill to the members of the Assembly.

While this has been a hard and trying year for this Committee, our labors have been considerably lightened because of the fine cooperation received in many quarters. The willing and intelligent cooperation of the Executive Officer, Mr. Bryan, has been of great assistance, and we have had the usual fine cooperation from the executive staff. Our Legislative Committee keymen continue to be keymen in fact. And, finally, we wish to pay a just and well-deserved tribute to President Schaaf for his splendid cooperation throughout his entire term.

We also wish to record appreciation of the effective help of the Woman's Auxiliary, and of the Advisory Committee on Conservation of Vision, Dr. Sherman was particularly helpful with respect to the Optometry Bill. We are indebted to the ophthalmologists throughout the state for their assistance. Dr. Schaaf and Dr. Quigley attended the legislative hearing on the disposition of the licensing boards. I was there, too, and I assure you that Dr. Schaaf's presentation was masterful, logical, and I think, impressive. Dr. Quigley handled the various members who composed the Council of Professions in an apt, diplomatic and effective manner.

PRESIDENT SCHAAF: This supplemental report will be referred to Reference Committee E, along with the original report on page 180 of the JOURNAL. The report of the Subcommittee on Medical Practice on page 184 of the April JOURNAL is referred to Reference Committee E. There is no supplemental report.

The report of the Subcommittee on Public Health, page 183 of the JOURNAL, will be referred to Reference Committee E. There is no supplemental report.

The report of the Subcommittee on Public Relations appears on page 181 of the April JOURNAL. This will be referred to Reference Committee E. There is no supplemental report.

The reports of the Advisory Committees to the Subcommittee on Public Health appear on pages 185 to 193 of the April JOURNAL. These reports will be referred to Reference Committee E, and I will ask Mrs. Madden if she knows of any supplemental reports on any of these Committees.

MRS. MADDEN: Not that I heard.

PRESIDENT SCHAAF: The reports of the Advisory Committees to the Subcommittee on Medical Practice will be referred to Reference Committee E.

The report of the Military Service Committee, appearing on page 173, will be referred to Reference Committee C.

The report of the Committee on Study of Medical Care appears on page 167 of the

April JOURNAL. That will be referred to Reference Committee C.

The report of the Veterans Liaison Committee appears on page 172 of the April JOURNAL and will be referred to Reference Committee C.

The report of the Medical-Surgical Plan, with the supplemental report that you heard before, will be referred to Reference Committee C.

The report of the New Jersey Health Congress on page 201 of the April JOURNAL will be referred to Reference Committee E.

I will ask Dr. Nichols if he has a supplemental report.

DR. NICHOLS: I am sorry it is such a late hour to bring you a two-page report, but there is a matter of importance in the line of the remarks that you have heard this afternoon. Here it is.

The organization of the New Jersey Health Congress has been presented in some detail, so that members of our society may have a knowledge of our efforts toward the end that good quality health services shall be gradually made available to all New Jersey's citizens. Every member of the medical, dental, nursing, pharmaceutical, and hospital professions should support this voluntary effort of our professions to work with (1) the New Jersey state governmental agencies officially concerned with health services and (2) the consumer statewide organizations, including labor, industry, agriculture, veterans, and health and welfare organizations, to see that good quality health services are widely available. In 1948 and 1949 there will be a drive on the part of advocates of governmental control of everything, including health services, to force Congress to create bureaucratic control of health services on many fronts, inciuding compulsory health insurance and many other laws of similar radical nature.

Next week in Washington, Federal Security Administrator Ewing, with the approval of President Truman, is holding a National Health Assembly, patterned largely after the National Health Conference of 1938. As pointed out by the American Medicai Association editorial, *"nineteen* of the *twenty-four* members of the Pianning Committee are aiready on record as outstanding advocates of compulsory health insurance". On the original Committee of twenty-four, there was but one doctor, Dr. Lull, General Manager of the American Medical Association. Inasmuch as the assembly is being planned by the same personnel who planned the 1938 Conference, it may be expected that the large majority of invited participants will. not be real representatives of governmental, medical, and voluntary health agencies, but will be carefuily handpicked because of their known views on socialized medicine. Study carefully the planning, proceedings, and recommendations of the National Health Assembly, so that you may become acquainted with this type of propaganda. It is a matter of profound regret that the American Medical Association is not this year holding its own National Health Congress as provided for by the House of Delegates of the American Medical Association in 1944. The 1944 A.M.A. House of Delegates, through a request from delegates from New Jersey, Illinois and Michigan provided for a National Heaith Congress under the Council on Medical Service. The matter was sidetracked in favor of the A.M.A.'s present fine expansion of voluntary health insurance, and buried by the A.M.A. House of Delegates of 1947 and 1948. We trust that the A.M.A. will profit by its experience with the National Health Assembly of 1938 and 1948 and resurrect its 1944 plan of holding its own National Health Conference at suitable intervals, with a democratic setup consisting of official representative delegates from medicai, governmental and voluntary agencies. Only this type of Conference can command real support from the participating agencies and carry the message of truth in its findings instead of propaganda.

I call your attention to the unhappy spectacle of the medical profession in Great Britain. When the British government takes over all British hospitals on July 1, 1948, the death struggle of the British medicai profession for medical freedom and private practice will begin. Of course, 89 per cent of the members of the British Medical Association have refused to accept the new law, which practically abolishes the private practice of medicine in Great Britain in favor of virtually complete bureaucratic control of British doctors. In view of the known plans for nationalization of American medicine by the research director of the Federal Security Administration, Falk, Davis and their followers, it could happen here and will, unless American medicine more vigorously constructs and promotes voluntary plans for making good quality medical services more widely availiable to every person in this country. The United States is the only large major country in the world, whose government is not yet in control of dictators and power hunters who rely on the evii doctrines of force and illwiil to hold their power and control everything including medical care, instead of the democratic approach. We have our own fifth column—our time is short and the sands of time are running low. Let us act now.

The only alternative to this prospect in these United States is the voluntary cooperation of (1) health professions, (2) governmental, and (3) voluntary health agencies, typified by the New Jersey Health Congress, to produce better quality, quantity, availability, and distribution of health services than has ever been attained in the world's history by any government controlied health service.

To strengthen this essential voluntary approach at county levels in New Jersey toward making medical services widely available to every citizen, it is recommended that The Medicai Society of New Jersey request each component County Medical Society to appoint a strong Committee on Council on Medical Service, as part of its program of good

public relations: it is recommended that the Committee's membership should include the Chairman of the Medical Practice Committee and the Chairman of the Public Relations Committee. They should make definite plans to see that good quality medical services are made available to every man, woman and child in their respective counties, with particular attention to the medical needs of persons in low income families.

PRESIDENT SCHAAF: Thank you, Dr. Nichols.

This supplemental report will be referred to Reference Committee E, along with the original report which appeared on page 201 of the April JOURNAL.

The report of the State Board of Medical Examiners appears on page 202 of the April JOURNAL. There being no supplemental report, the original report will be referred to Reference Committee D.

I will now call for resolutions, memorials, amendments to the Constitution or other new business from the county medical societies.

DR. NORTON: Mr. President, I have been handed these two matters by the Hudson County Medical Society.

"By action of the Hudson County Medical Society, the House of Delegates is requested to ask the Commissioner of Motor Vehicles to issue specially marked automobile license plates to doctors of medicine in order to alleviate the known parking and traffic difficulties encountered particularly in many areas of this state."

PRESIDENT SCHAAF: This resolution will be referred to the Committee on Resolutions.

DR. NORTON: Another: "The House of Delegates by action of the Hudson County Medical Society, is requested to ask the Commissioner of Labor to review the status of medical testimony offered in the Compensation Courts, and further requests that he make to this Society whatever recommendation he deems pertinent in this matter."

PRESIDENT SCHAAF: We will ask that this be put in the form of a resolution and referred to the Committee on Resolutions and Memorials.

Has anyone else a matter of new business, a resolution, change of the Constitution, or anything which should be presented to this session? No new business can be presented to the House of Delegates after this meeting except by unanimous consent, so hearing no new business, this will terminate our program.

The Commander of the Willow Grove Naval Air Station requests the following announcement be read:

"The Naval Air Reserve Training Command, with headquarters at Naval Air Station, Glenview, Illinois, has eighteen nationally located Naval Air Stations and four Naval Air Reserve Training Units at which Naval Reserve Medical Officers may serve on active duty with full pay and allowances and with the privilege of returning to civilian life at any time upon request. Additional details may be obtained from Chief of Naval Air Reserve Training, Naval Air Station, Glenview, Illinois."

One of the requirements of the presidency is that the retiring President deliver an address. It is now five-thirty, you have been in session three and a half hours, so I am going to spare you the reading of this, but will incorporate it in the record for future publication,* with the permission of this House. Do I have the permission?

(Motion was made and passed.)

DR. STOKES: Dr. Schaaf, we have heard so much spoken of here today on compulsory health insurance. I am just wondering whether we ought to send a note to our Senator Alexander Smith in Washington expressing our appreciation for his requesting the Brookings Institution to make a study of compulsory health insurance in this country.

The Brookings Institution has just published a summary of their report, and it is a very excellent report in which they suggest that the federal government do nothing about compulsory health insurance but encourage voluntary health measures. I think Senator Smith has done our medical profession a very distinct service in asking the Brookings Institution to make this study. It is probably the best thing that has ever been done.

PRESIDENT SCHAAF: Do you wish that in the form of a resolution?

DR. STOKES: If the House of Delegates sees fit to do it. I put it in the form of a motion.

(The motion was seconded, put to a vote and carried.)

PRESIDENT SCHAAF: The motion is carried and we will ask you to put it in the form of a resolution and present it to the Reference Committee on Resolutions and Memorials.

The House adjourned at 5:35 p. m.

* See page 43 these TRANSACTIONS.

Wednesday, April 28, 1948

. . . . The meeting of the House of Delegates convened in the Viking Room, Haddon Hall, Atlantic City, at twelve o'clock noon. Doctor Royal A. Schaaf, President, presiding. . . .

PRESIDENT SCHAAF: The meeting will please come to order. At this session of the House of Delegates no business may be transacted except that of the annual election. Dr. Lewis will give us a report of the delegates registered and in attendance.

DR. LEWIS: Delegates registered 239. Total number of members 772. Total registration 1473 which is 100 more than the total last year.

PRESIDENT SCHAAF: Thank you, Dr. Lewis.

I would like at this time to recognize and introduce as the second delegate from the State of New York, Dr. Reuling. Will he please come forward and say a word?

DR. REULING: It is a great pleasure to be at the Annual Meeting of The Medical Society of New Jersey. You are to be congratulated on the apparent strength that I have seen in your county societies. Medicine is being beset by many devils, mostly from the top and well organized. However, our strength lies in the county societies. And I noticed that strength at this meeting. In the county society we can guide, we can direct and if necessary pull into line and censure members who get out of line. New Jersey is one of our strong bulwarks against the encroachment that we are all witnessing and that we all hope to be able to avoid.

It is a pleasure to be here. Thank you very much.

PRESIDENT SCHAAF: Thank you, Dr. Reuling. We appreciate your kind remarks very much and we appreciate even more the fact that you were willing to come.

Our Secretary, Dr. Wood, unfortunately was called home and it becomes necessary for me to designate a secretary *pro tem.* For this, I name the chairman of the Welfare Committee, Dr. Vincent P. Butler who will act as secretary *pro tem.*

A quorum consists of 20 members from 4 component societies. I ask the Secretary whether there is a quorum present.

SECRETARY BUTLER: A quorum is present.

PRESIDENT SCHAAF: The only business that will come before this meeting is the annual election. I call upon Dr. Londrigan to submit his report.

DR. LONDRIGAN: This is the report of the nominating committee which met last evening.

For *President-elect:* James F. Norton, Jersey City, for a period of one year.

First vice-president: Aldrich C. Crowe, Ocean City, one year.

Second vice-president: Sigurd W. Johnsen, Passaic, one year.

Secretary: Earl LeRoy Wood, Newark, one year.

Treasurer: George J. Young, Morristown, one year.

Trustees: Second district: J. Lawrence Evans, Woodcliff, three years; Third district: L. Samuel Sica, Trenton, three years; Fourth district: Reuben L. Sharp, Camden, three years; Fifth district, David W. Green, Salem, three years.

Councilors: First district: Francis C. Weber, Newark, three years; Fourth district: D. F. Featherston, Asbury Park, three years.

American Medical Association Delegates and Alternates for 1949 and 1950 meetings: Delegate, J. Wallace Hurff, Newark, two years; Alternate: Elmer P. Weigel, Plainfield, two years; Delegate, David B. Allman, Atlantic City, two years; Alternate, William E. Bray, Pemberton, two years; Delegate, Thomas K. Lewis, Camden, two years; Alternate, Clarence W. Way, Sea Isle City, two years.

Delegate to Connecticut, 1949: Alfred Stahl, Newark, one year; Alternate, C. Byron Blaisdell, Long Branch, one year. *Delegate to New York:* James F. Norton, Jersey City, one year; Alternate, D. Ward Scanlan, Atlantic City, one year.

Standing committees: Finance and Budget, Herschel S. Pettit, Ocean City, six years; Publication, Henry C. Barkhorn. Newark, three years; Scientific Work, Harold S. Davidson, Atlantic City, five years.

PRESIDENT SCHAAF: It has been moved and seconded that the report of the Nominating Committee be received. Those in favor please indicate by saying "Aye".

(The motion was unanimously carried.)

DR. NORTON: Mr. President, Members of the House of Delegates: As a part of the report of this nominating committee we now submit an item with which the delegates should be familiar. For many years some members of this Society have served with credit, honor and distinction; and by all the standards usually applied in such cases of distinguished service should and would be continued in their present positions. Each now chooses not to stand for reelection.

The nominating committee, therefore, requests this House of Delegates by appropriate action, if necessary by a suspension of the rules, to take notice of their noteworthy service and contribution to the affairs of the Society and to the cause of organized medicine in general.

Dr. Hilton S. Read of Atlantic County has served for a period of 13 years as a delegate to the American Medical Association, and for personal reasons has requested that he be relieved of further service.

Dr. Thomas Lee of Camden County has for almost twenty years served faithfully, honorably and creditably as a member of the Board of Trustees, and he too for personal reasons has asked for no further consideration.

It is requested that notice be taken of the services of Dr. S. Emlen Stokes as Councilor, and of Dr. Lancelot Ely as an alternate delegate to the American Medical Association.

PRESIDENT SCHAAF: Thank you, Dr. Norton. I am sure that tomorrow afternoon the House of Delegates will be willing to give unanimous consent to a suspension of the rules to let us introduce a suitable resolution to memorialize these gentlemen, and I will entertain a motion for the appointment of a committee to draw up a suitable resolution to properly memorialize these gentlemen.

A DELEGATE: I so move.

A DELEGATE: I second the motion.

PRESIDENT SCHAAF: You have heard the motion made and seconded. Those in favor please indicate by saying "Aye"; those opposed "No".

(The motion was unanimously carried.)

We will now proceed to ballot for the various offices.

The name of each candidate was separately read out. There was, for each office, a call from the Chair for nominations from the floor. No additional nominations were made. In each case a motion was made, seconded and passed, to close nominations. And for each office there was made, seconded and passed a motion to instruct the secretary to cast one ballot for the candidate. Thus each candidate listed on page 25 of these TRANSACTIONS was declared elected.

PRESIDENT SCHAAF: This concludes the business of this session. The House stands adjourned until 1:30 p. m., April 29, 1948.

Thursday Afternoon Session—April 29, 1948

The meeting convened at 1:45 p. m., President Schaaf presiding.

President Schaaf: The meeting will please be in order. Is there a quorum present? The secretary says there is, and I am going to ask for suspension of rules to present a few complimentary resolutions. For the record I wish to note the sorrow which we all feel over the sudden and untimely death of Dr. Schlichter. He was with us last night, apparently in good health, went home and shortly thereafter died of a heart attack. I am sure we will miss the presence of a genial, kindly, friendly and competent man.

May I have the vote on the suspension of rules?

(Motion was made to suspend rules. The motion was seconded, put to a vote and carried.)

President Schaaf: I will ask the secretary to read several resolutions memorializing the services of different men.

Secretary Butler: "Resolution memorializing the services of Hilton S. Read, M.D.

"Whereas, Hilton S. Read, M.D., has for thirteen years served as a delegate to the American Medical Association, and during that period has traveled to the four corners of the nation in the interest of this society, laboring indefatigably and effectively on behalf of his fellow practitioners; and

"Whereas, He has for eight years served as Chairman of the Welfare Committee, performing that important function with grace, adroitness and consummate skill; and

"Whereas, He has refused any consideration at this time for further office within The Medical Society of New Jersey; therefore be it

"Resolved, That speaking through its House of Delegates, The Medical Society of New Jersey hereby places on record its appreciation of the long, loyal, and creditable service rendered to it by Dr. Read; and be it further

"Resolved, That a copy of this resolution be transmitted to the press, that the text be spread on the minutes of the House of Delegates and published in its Transactions, and that a copy signed by the President of this Society be personally transmitted to Dr. Read."

Dr. Allman: I move the adoption of that resolution.

President Schaaf: It has been moved and seconded that this resolution memorializing the services of Dr. Read be spread upon the minutes.

(The motion was carried unanimously.)

Secretary Butler: This is a resolution memorializing the services of Thomas B. Lee, M.D.

"Whereas, Thomas B. Lee, M.D., has for almost two decades served as a Trustee of The Medical Society of New Jersey; and

"Whereas, During that period he was a faithful member of the Board, attending meetings regularly, year in and year out, often at great personal inconvenience; and

"Whereas, He was always an alert, active, and effective member of the Board, one who had served as its chairman with grace, distinction and impartiality, one whose wise and mature counsel consistently proved a tower of strength and a source of inspiration to his fellow trustees; and

"Whereas, Having sacrificed so much of himself and his health in the service of his fellow practitioners, he now finds it necessary to retire from the office he has held with such honor, now, therefore, be it

"Resolved, That speaking through its House of Delegates The Medical Society of New Jersey, hereby places on record its appreciation of the long, loyal and creditable service rendered to it by Dr. Lee; and be it further

"Resolved, That a copy of this resolution be transmitted to the press, that the text be spread on the minutes of the House of Delegates, and published in its Transactions, and that a copy signed by the President of this Society be personally transmitted to Dr. Lee."

President Schaaf: You have heard this resolution memorializing the great service of Dr. Lee. What is your pleasure.

(Motion was made and seconded and unanimously passed.)

Secretary Butler: "Resolution memorializing the services of Lancelot Ely, M.D.

"Whereas, Among the small and honorable company of Fellows of The Medical Society of New Jersey, one of the most distinguished is Lancelot Ely, M.D.; and

"Whereas, After many years of faithful service as an alternate delegate to the American Medical Association, Dr. Ely finds it necessary to retire from such service; and

"Whereas, In his capacity as alternate delegate, Dr. Ely consistently, effectively and creditably, labored for the interests of the people and profession of New Jersey; now, therefore, be it

"Resolved, That the House of Delegates of The Medical Society of New Jersey hereby places on record its appreciation of this distinguished service, and be it further

"Resolved, That the text of this resolution be transmitted personally to Dr. Ely and that a copy thereof be spread on the minutes of this House."

President Schaaf: You have heard the resolution memorializing the notable services of Dr. Ely. May I have a motion?

(Motion was made and seconded and unanimously passed.)

SECRETARY BUTLER: "Resolution memorializing the services of S. Emlen Stokes, M.D.

"Whereas, During a period of many years, S. Emlen Stokes, M.D., has served with distinction and tact in the difficult office of Judicial Councilor of The Medical Society of New Jersey; and

"Whereas, Dr. Stokes now finds it necessary to withdraw from further service in that capacity; now therefore, be it

"Resolved, That this House go on record as noting with regret Dr. Stokes' decision to retire from further service as a Judicial Councilor, and that this House, as a token of appreciation for the many years of such service, so honorably and faithfully rendered, hereby spread on its minutes this memorial of appreciation and gratitude; and be it further

"Resolved, That a copy of this resolution, signed by the President of The Medical Society of New Jersey, be personally delivered to Dr. Stokes, and that other copies be released to the press and recorded in the TRANSACTIONS of this 1948 Annual Meeting."

PRESIDENT SCHAAF: You have heard this resolution memorializing the services of Dr. Stokes. What is your pleasure?

(Motion was made and seconded, and unanimously passed.)

SECRETARY BUTLER: The following resolution was presented by Dr. Cosgrove of Hudson County:

"Resolved, That in the absence of the delegates from the Connecticut Medical Society, Dr. David F. Conway, Jr., New Haven, be accredited by this Convention as the delegate from the Connecticut Medical Society."

PRESIDENT SCHAAF: You have heard this resolution. What is your pleasure?

(Motion was made and seconded and passed.)

PRESIDENT SCHAAF: Two years ago The Medical Society of New Jersey felt it incumbent to recognize distinguished service which might have been rendered to the Society by non-medical persons. The change in the Constitution was effected by a first reading in 1946 and it was passed on second reading at the meeting in 1947 and immediately thereafter the first honorary member was elected, in the person of Mr. John S. Thompson, who had rendered distinguished service to the Society by his actuarial guidance of the Medical-Surgical Plan.

Today the Society proposes to honor another non-medical person who has also rendered long and very distinguished service to this Society. I shall ask the Secretary to read Paragraph 8 of the report of the Resolutions and Memorials Reference Committee. Will the Secretary please read this?

SECRETARY BUTLER: "Unanimous approval was given to the report of the Honorary Membership Committee nominating for Honorary Membership in The Medical Society of New Jersey Mr. William H. MacDonald, Chief, Local Health Division, New Jersey State Department of Health, in recognition and appreciation of his many years of assistance to and cooperation with the State Society."

PRESIDENT SCHAAF: You have heard this recommendation of the Reference Committee on Resolutions and Memorials. What is your pleasure?

The motion was made, seconded, and unanimously passed. Amid applause, Dr. Warter and Mr. MacDonald ascended the platform.

PRESIDENT SCHAAF: In making this citation, I have asked a long-time friend to tell us something about Mr. MacDonald's background. Dr. Warter—

DR. PETER J. WARTER (Mercer County):

For many years William Henry MacDonald has been associated with the New Jersey State Department of Health. Serving in many capacities and in different communities, he eventually became chief of the Bureau of Local Health Administration, now known as the Bureau of Local Health Services.

Mr. MacDonald was born November 27, 1888, in South Brunswick Township, Middlesex County, New Jersey, son of Henry and Nettie F. (Dey) MacDonald, both natives of this state. The MacDonald family came to America in the early days of the Revolution, while the Deys were among New Jersey's early settlers.

William Henry MacDonald attended New Brunswick High School, and Rutgers Preparatory School. In 1911, he received the degree of Bachelor of Literature from Rutgers University, and in 1925, he received the Master of Science degree there. Mr. MacDonald had been connected with the health department of the city of New Brunswick. After graduation, he became associated with the Lederle Laboratories.

In 1912 he entered the New Jersey State Board of Health as a sanitary inspector. The department to which he was assigned was called the Bureau of Medical and Sanitary Inspection, now known as the Bureau of Local Health Services. For a time Mr. MacDonald served as district health officer, with headquarters at Freehold, then became acting chief of the bureau, in Trenton. At length he was made chief of the bureau, in which capacity he continues today. When he entered the department many years ago, six people were employed in this bureau of the department, but growth has been so consistent and extensive that there is now a personnel of fifty people.

During the first World War he was in direct charge of public health work at Camp Dix, and during the second World War, he served as Deputy Coordinator of Medical Services. He is a mem-

ber, and indeed past president of, the New Jersey Health and Sanitary Association. Currently he is vice-president of the N. J. Tuberculosis League, and has for many years been an active member of the executive committee of the N. J. Health Officers' Association. He is, of course, a member of the American Public Health Association. As a hobby, Mr. MacDonald enjoys athletic activities, having been particularly active in track work while in college. He retained the 220 and 440 yard record at Rutgers for a number of years. He was captain of the track team and president of the senior class. He is an ardent student of history, and a member of the Monmouth County Historical Association. He derives special satisfaction from collecting antiques, especially powder horns and flasks. He is a member of the New Jersey Arms' Collectors Association. He enjoys, too, collecting information about old chairmakers. He has written a brochure on "Chairmakers of Monmouth County," and has in his possession a number of antique chairs and chairmakers' tools. He collects old clocks and puts them into working condition and he enjoys refinishing old furniture so that it can be used. Both he and his wife are members of the First Presbyterian Church of Trenton.

Mr. MacDonald has been coordinator to the Public Health Committee of The Medical Society of New Jersey for fifteen years. He was also a member of the A.M.A. Survey Group on Medical Care in 1938. He was one of two men who made the recent survey on hospital construction for the State of New Jersey. Hardly a week goes by that he is not consulted by our Society on health problems. He has always given willingly and unstintingly of his time to health problems concerning the medical profession in New Jersey and their relationship to the public.

In 1914, Mr. MacDonald married Beulah Mae Hubbard of New Brunswick. She is a descendant of Dr. Jacobus Hubbard, a surgeon during our Revolutionary War. The great pride of their lives was William, junior, born in October 1916. He entered the service of our country in 1942, and two years later was killed in air combat over Germany. The MacDonalds past and present, as you see, have served their state and nation long, nobly and well.

President Schaaf: Thank you, Dr. Warter, for this beautiful biography which you presented so graciously.

I now read the citation. "The Medical Society of New Jersey. To all whom it may concern, greetings. This citation is presented to William Henry MacDonald, M. S., for his appreciation of the ideals and purposes of the medical profession and for his many years of assistance to and cooperation with the Society and to him is granted an Honorary Membership in The Medical Society of New Jersey, with all the rights and privileges appertaining thereto. In testimony whereof, the signatures of the proper officials and the seal of the Society are affixed at Atlantic City, New Jersey, this twenty-ninth day of April in the year of our Lord, one thousand, nine hundred forty-eight."

Mr. MacDonald, I present this with our thanks.

Mr. MacDonald: Dr. Schaaf, Dr. Warter, Officers of the Association, and Members of the House of Delegates: It is indeed a very gracious thing for you to extend to me this honor and distinction. I feel quite humble and undeserving, but of course very appreciative of this honor.

I think I will have to tell you one little item about myself which Dr. Warter did not mention; that is, as a boy, like other boys, I liked to play long and hard. And like many other boys I had a hobby for rainy days. My hobby was to make medicine. I used concoctions of flour and water and vinegar and salt and pepper and sugar, which I carefully bottled and labeled. The more smelly the concoction, the more potent, in my opinion, it was. In other words, I wanted to be a doctor. Well, for one reason or other I never reached that goal. However, the desire was there and your action in making me an Honorary Member of your Association has, as you might realize, gone far to make up for the lack of ability I had in reaching my boyhood goal.

If I live to a hundred I certainly shall look back upon this day and this hour as being one of the highlights of my life.

President Schaaf: So often when we honor a man we forget that he has a wife. I'd like to present Mrs. MacDonald. (Applause.) And in connection with this citation, I ask the Secretary to read a telegram from the Director of Health, Dr. Mahaffey, which was sent here in recognition of the Honorary Membership which we have conferred on Mr. MacDonald.

Secretary Butler: This telegram is addressed to Chester I. Ulmer, care of The Medical Society of New Jersey, Atlantic City.

"Dr. J. Lynn Mahaffey wishes to express his regrets that it will be impossible for him to attend this meeting of The Medical Society of New Jersey as he is at present ill in Cooper Hospital. He asks you to convey to the group in Atlantic City how much he appreciates the fact that the Society is honoring William H. MacDonald, who has served the State Department of Health well for many years. Mr. MacDonald is the connecting link between the State Department of Health and The Medical Society of New Jersey, and has worked for more than thirty-five years with local boards of health throughout the state. It is most pleasing to Dr. Mahaffey, this Department, and the Public Health Council that Mr. MacDonald has been selected for this honor."

It is signed, "The State Department of Health, Charles M. Callahan, Chief of the Division of Personnel, Records and Accounts."

PRESIDENT SCHAAF: You have heard this telegram from Dr. Mahaffey. A motion would be in order to thank Dr. Mahaffey and also to offer him our sympathy on his illness.

(Such a motion was made, seconded and passed.)

PRESIDENT SCHAAF: We will now ask the secretary to read the resolution in memoriam of Dr. Schlichter.

SECRETARY BUTLER: "Whereas, Almighty God in His wisdom has seen fit to call our esteemed colleague, Dr. Charles H. Schlichter to his eternal reward; and

"Whereas, Dr. Schlichter has for many years contributed his time and energy unselfishly in the interest of the medical profession as a citizen, as a member of this Society and as a member of this House of Delegates; and

"Whereas, Dr. Schlichter has been, not only an outstanding physician, but a man whose conduct of life has set a pattern which might well be emulated by all of us, and who has gained the respect, esteem and love of all people with whom he has come in contact as a friend or colleague; therefore be it

"Resolved, That this House of Delegates in assembly at its Annual Meeting this date express its deepest sorrow for the passing of its esteemed member, and express to the bereaved family its deepest sympathy; be it further

"Resolved, That this Resolution be spread upon the minutes of this meeting and that a copy of this Resolution be sent to his faithful companion for over fifty years, Mrs. Schlichter."

PRESIDENT SCHAAF: You have heard this resolution. What is your pleasure?

(The motion was made, seconded and passed.)

PRESIDENT SCHAAF: We will now resume operation under rules. The first item is the report of the Reference Committee on Constitution and By-Laws, by Dr. Edward W. Sprague.

DR. SPRAGUE: The following proposed amendments to the by-laws were considered:

"(1) Chapter VIII, Section 2, Standing Committees:

Delete the words 'Post-Graduate Education Committee' and substitute the words 'Committee on Medical Education'.

"(2) Chapter VIII, Section 11:

Delete the present title 'Committee on Post-Graduate Education' and substitute the title 'Committee on Medical Education'.

"(3) Chapter VIII, Section 11: first sentence:

Delete the words 'Committee on Post-Graduate Education' and substitute the words 'Committee on Medical Education'.

The three proposed amendments which relate to the same subject are approved by the Reference Committee and are recommended for adoption by the House of Delegates. Next we recommend the following:

"(4) Chapter VIII, Section 10:

Delete the words 'The Welfare Committee shall consist of thirty-five members' and substitute the words, 'The Welfare Committee shall consist of not more than sixty members, exclusive of consultants'."

The proposed amendment is approved by the Reference Committee and is recommended for adoption by the House of Delegates. We also recommend the following:

"(5) Chapter VIII, Section 10:

Delete the words 'Special Advisory Committees of five members each,' and substitute the words, 'Special Advisory Committees of not more than fifteen members each'."

The proposed amendment is approved by the Reference Committee and is recommended for adoption by the House of Delegates.

Each of these five proposals was separately considered, and each was unanimously approved by the House of Delegates, and President Schaaf declared them adopted and effective immediately.

DR. SPRAGUE: This is from the supplemental report of the Board of Trustees referred to us as follows:

Part 1. Criticism of the Society has been made because at present there is no group within the organization to which complaints from lay groups can be referred.

The Board of Trustees recommends that this matter be referred to the Reference Committee on Constitution and By-Laws for consideration.

It is the opinion of the Reference Committee that there is need for an established avenue for complaints from lay groups or persons and the Judicial Council is the proper body of the Society to receive and consider them.

Therefore, the Reference Committee recommends the following amendment to the By-Laws:

Chapter VII, Section 4:

That the following sentence be added to Section 4: "It shall also consider complaints of lay groups or persons against members of this Society".

PRESIDENT SCHAAF: Mr. Chairman, I have consulted with the Parliamentarian and we think that this can be passed and be regarded as the second reading since the Board of Trustees approved the principle that was placed be-

fore the Delegates and the Reference Committee was asked to formulate the change.

DR. SPRAGUE: I will move the adoption of this amendment to the By-Laws.

The motion was seconded, unanimously carried, and President Schaaf declared the amendment effective immediately.

DR. SPRAGUE: We were also asked to consider clarification of Article VI of the Constitution, which lists the "junior past-president" as a member of the Board of Trustees. Dr. Schaaf has stated that the wording is indefinite. Does it mean the most junior surviving past-president, or if the immediate past-president is not available, does it mean that the position remains unfilled? We have an example in the current Board of Trustees as Dr. Scammell died before completing his term as a member of the Board, which left a vacancy. Should interpretation of this Article be that in the event of death or incapacity of the junior past-president the vacancy on the Board is not filled, or should the Article be amended to read "the *immediate* Past-President, if living or able to serve."

The Board of Trustees recommends that the matter of clarification of Article VI of the Constitution be referred to the Reference Committee on Constitution and By-Laws.

It is the opinion of the Reference Committee that this will be definitely clarified by deleting the words "junior past-president" and substituting the words "immediate past-president" wherever "junior past-president" appears in the Constitution or By-Laws.

Therefore, the Reference Committee recommends the following amendment to the Constitution.

Article VI—Board of Trustees:

Delete the words "Junior Past-President" and substitute the words "Immediate Past-President".

PRESIDENT SCHAAF: I think the motion should be to approve the recommendation because it has to be read again.

DR. LONDRIGAN: Does that word "immediate" in place of "junior" change in any way the article?

PRESIDENT SCHAAF: It does not change the intent of the article. When Dr. Scammell died should Dr. Alexander, who was then the next junior past-president, be moved up into the Board again? The purpose of keeping the past-president on for a year was to give the Trustees the benefit of certain continuity of service for a year, so that he wasn't suddenly off the Board and they didn't know what he had done about certain things. But it wasn't contemplated to be an extra vacancy which must be filled.

DR. LONDRIGAN: My question is only for information, Mr. President. My interpretation would be that the immediate Past-President is the fellow who died and he is still immediate Past-President.

PRESIDENT SCHAAF: That is correct. That is what it is supposed to be.

DR. LONDRIGAN: How can he serve if he is dead?

PRESIDENT SCHAAF: He can't. The point is that we want it made clear that nobody is to be moved into that.

DR. SPRAGUE: The vacancy cannot be filled.

PRESIDENT SCHAAF: We will regard that as the first reading and then hold it until next year for a second reading, at which time, if approved, it will be part of the Constitution.

(Dr. Sprague then read the amendments to Chapter V of the By-Laws, replacing the word "junior" with "immediate".)

PRESIDENT SCHAAF: We can also regard this as the second reading because it was implicit in reference to the Trustees and we will therefore entertain a motion to approve this change in the By-Laws.

DR. SPRAGUE: Mr. President, I move the change.

(The motion was seconded and passed.)

DR. SMITH (Middlesex County): Mr. President, if you amend the By-Laws, change that wording in the By-Laws without changing the wording in the Constitution there is going to be confusion.

DR. SPRAGUE: We made the changes in the Constitution and By-Laws.

DR. SMITH: But you can't approve the Constitutional changes at this time; you have to wait until next year on the Constitutional changes. That means in one year there is going to be confusion.

PRESIDENT SCHAAF: There will be confusion only if I kicked the bucket between now and next July. I'll try not to do that.

DR. SPRAGUE: I move the report as a whole be adopted.

(The motion was seconded and passed.)

PRESIDENT SCHAAF: We will now hear from Reference Committee A, Dr. Read.

DR. HILTON READ (Atlantic County): Your Reference Committee met and surveyed the report of the President. We found ourselves in complete agreement with it.

Among the many splendid accomplishments during the past year, we would especially commend Dr. Schaaf for the *President's Page*. Your Reference Committee feels, as must the

membership at large, that Dr. Schaaf exemplifies attributes of leadership not too common.

His ability to organize and administer the manifold duties of his office has not been surpassed by any president within our recollection. Dr. Schaaf takes justifiable pride in his accomplishments of completing the staff of the executive offices by the appointment of the Executive Officer, Mr. Bryan.

President Schaaf has energetically and most ably represented the Society in personal contacts and negotiations with numerous cooperating agencies during the year. Further, with the aid of the other presidential officers, he has greatly increased our contacts with the individual county societies. Wherever he has gone, Dr. Schaaf has added to the prestige and influence of the Society because of his diplomatic approach and talent for conciliation.

His enthusiastic approval of the idea of a medical school in New Jersey should be construed as only his personal opinion until an accurate referendum of the membership at large has been obtained.

Your Committee reviewed with interest the report of the Secretary and would recommend that each component society undertake a dignified membership drive in order to approach the late Bill Carrington's suggestion that every recognized doctor of medicine not in jail should be in organized medicine. It is to be remembered that our representation in the A.M.A., for instance, is directly proportional to the number of Fellows of the A.M.A. in this state. That figure is obviously at variance with the number of the members of The Medical Society of New Jersey and efforts should be made to insure each member of The Medical Society of New Jersey becoming a Fellow of the A.M.A. as well.

Failure to submit an affirmative report by the Judicial Council was occasioned only by the lack of presentation of problems to them. This Council is an ever present bulwark and even its masterful inactivity requires commendation.

Not only this formal report of the Board of Trustees, but also the minutes of this important segment of organized medicine as they appear in the monthly Journal reflect the back-breaking job that these gentlemen accomplish. We commend these men to you that you may extend them unstinting support, an enduring affection and unlimited respect for the thankless job they discharge in your interest and in the interest of the consumers of medical care in New Jersey each of the 366 days just now being consummated.

Your Committee has studied with interest the report of the Executive Officer as published in The Journal and the supplementary report as delivered to this House. We especially commend his suggestion that we have adequate blue prints, that now what we need is action. I quote an especially apt paragraph:

"The Medical Society of New Jersey, it seems to me, is well equipped with policies and objectives. You have well defined attitudes and plans with respect to nearly every issue or problem confronting you. The job, now, is execution. The need is to make your proposals come true."

We bespeak the translation of this to your county society and to your individual colleagues. Your Reference Committee recommends that we stop just thinking and hoping and that we take off our coats and go to work.

After each section of the report, Dr. Read moved the adoption of that section; and by vote, each was adopted. Then:

Dr. Read: I move adoption of the report as a whole.

Motion was seconded and passed to that effect.

President Schaaf: Thank you very much, Dr. Read, particularly for those felicitous phrases in the first part. I see Mr. William Burns, Executive Secretary of the Michigan State Medical Society is here. We make him welcome and ask him for a few words.

Mr. William Burns (Lansing, Michigan): Thank you, Mr. President. It has always been my maxim that an Executive Secretary should be seen and not heard. Part of the job is to find fault with ourselves and to try to do a better job than was done last week and especially last year. That is one of the reasons why I am in New Jersey, because I am getting ideas from the fine work the folks here in the front row are doing. And to be critical of ourselves we must improve the State Medical Society for which we work. In my work as a critic of what is going on I find a great deal of interest roaming around the country to the better organized State Medical Societies in picking up ideas.

Officially I am instructed to bring greetings to you from the Michigan State Medical Society and hope that we may be invited back to this state some other time and that as often as possible you will come to Michigan, especially in the summer time when we have sunshine. Thank you very much.

President Schaaf: Thank you, Mr. Burns, for your brilliant remarks. The Reference Committee on Resolutions and Memorials was under the chairmanship of Dr. Cosgrove, who unfortunately was called away. They had a

voluminous amount of business to transact, they worked till late in the evening, and they put it in good shape, and I am going to ask the Secretary to read the report and we will adopt it or disapprove it item by item.

Secretary Butler: There was referred to the committee a communication from Dr. H. A. Brodkin of Essex with reference to biologic and bacterial warfare. After careful consideration, we feel that it would be impracticable and unfair for this organization or the A.M.A. to attempt to control the conscientious reactions of any of its members under combat conditions; but that each individual so engaged must be left free to conform his conduct under any particular circumstances to his own conscience and to the exigencies of the situation in which he finds himself.

Your Committee would recommend that the House of Delegates adopt the following resolution:

1. That whereas the employment of biologic and bacterial technics of warfare is inhumane in subjecting vast numbers of noncombatant inhabitants of combat areas to its jeopardies, now therefore

Be It Resolved, by The Medical Society of New Jersey that it declare its strong belief in the essential inhumanity of such technics of warfare and its further belief that those technics should be outlawed by international cooperative agreement, and

Be It Further Resolved, that our Delegates to the American Medical Association be instructed to endeavor to have a resolution similar to this one adopted by that body.

I move the adoption of this resolution.

The motion was seconded and passed and the resolution adopted.

Dr. Butler: The Committee considered the resolution on the World Health Organization and unanimously approved the resolution in an amended form as follows:

2. *Whereas,* the World Health Organization of the United Nations is potentially one of the most important agencies in promoting world peace, as well as in safeguarding and enhancing world health and welfare, and

Whereas, the United States was a leader in the formation of the World Health Organization at San Francisco in 1945 and subscribed to the Constitution of the World Health Organization in New York in 1946, and

Whereas, in 1947 the United States Senate passed a bill to make the United States a signatory to the World Health Organization and the Committee on Foreign Relations of the House of Representatives has approved a similar bill, and

Whereas, the Committee on Rules of the House of Representatives on March 12, 1948, by a divided vote placed this proposal indefinitely upon the table, thus preventing action by the House of Representatives, and

Whereas, more than the required minimum of twenty-six nations have become signatories to the World Health Organization and have thereby established this organization without United States participation, and

Whereas, if the recent action of the Rules Committee stands, the United States will be excluded from official participation in the formulation of world health programs and by its self-exclusion, the United States will deprive the world Health Organization of the considerable part of its necessary funds which were expected from the United States on the assumption that it would become a member thereof, and

Whereas, the World Health Organization has been approved and, to a degree, sponsored by the American Medical Association, the American Public Health Association, and virtually every other national health organization in the United States, therefore be it

Resolved, that The Medical Society of New Jersey record itself as earnestly favoring the adherence of the United States to the World Health Organization of the United Nations in the interest of promoting world peace, the advancement of health standards throughout the world, and the enhancement of the welfare of the United States, as well as all the United Nations; and be it further

Resolved, that The Medical Society of New Jersey urgently petition the Rules Committee of the House of Representatives to reconsider the report on the World Health Organization of the Committee on Foreign Relations to the end that, if possible, it be placed on the calendar for earliest possible action by the House of Representatives; and be it further

Resolved, that copies of this resolution be transmitted to each member of the Rules Committee, the Speaker and Majority Leader of the House of Representatives, the members of the House from the State of New Jersey, and the President of the United States.

I move the adoption of this resolution.

The motion was seconded and passed and the resolution was adopted.

Dr. Butler: The Committee decided it was premature to present the resolution on Better School Health Programs to the A.M.A. at this time and recommends that no communication to the A.M.A. be issued on this matter at this time.

This recommendation was approved by vote.

Dr. Butler: There was before your Committee a communication from certain members of the Hudson County Medical Society with reference to the presentation and receipt of medical testimony in the compensation courts of this state; your Committee unanimously recommends that this be referred back to the Hudson County Medical Society for further

study and subsequent recommendation to the State Society. The feeling of the Hudson County delegates is that we were instructed to present this to the House of Delegates as a matter for either the House of Delegates or the Board of Trustees to take some suitable action, and regardless of whether it is approved by the House of Delegates today or not it goes back to the Hudson County Medical Society; it would then be referred to the Board of Trustees.

So that while Dr. Cosgrove's recommendation here is that subsequent study and recommendation be made by the Hudson County Medical Society, it seems more feasible that the House of Delegates directly refer it to the Board of Trustees, and if it is not out of order I would so recommend.

4. I move that this report be disapproved and that the matter be referred to the Board of Trustees. I so move you, Mr. President.

The motion was seconded and carried. Accordingly this will be referred to the Trustees for further consideration.

Dr. Butler then read the following resolutions, each of which was separately presented to the house and each of which was adopted on motion made, seconded and carried.

5. A resolution requesting the Commissioner of Motor Vehicles to issue special license plates for M.D.'s was unanimously approved as presented.

6. The Committee considered the resolution regarding a Survey Committee on Medical Schools in New Jersey and unanimously approved the resolution in an amended form as follows:

Whereas, the standards of medical practice, and consequently, the health level of a community are elevated by the existence of an approved medical school in the area in which it serves, and

Whereas, there is at present no medical school in New Jersey, and

Whereas, collegiate educational facilities of all kinds, except in medicine and dentistry, are available to the people of this state, and

Whereas, many physicians, educators, and influential members of the lay public have long believed that a medical school is needed in New Jersey, and

Whereas, unless new or additional facilities are developed for the education of a large number of physicians there may be a serious shortage of medical personnel by 1960, and

Whereas, the State University at Rutgers is at the present time expanding existing and adding new facilities for collegiate education and is considering general aspects of the problem of establishing a medical school, and

Whereas, a high grade medical school can only be developed with wholehearted cooperation on the part of the medical profession in the area in which it is to be established, and

Whereas, the Board of Trustees of The Medical Society of New Jersey has endorsed the principle of an approved medical school under university auspices and supported by general tax funds, therefore be it

Resolved, that The Medical Society of New Jersey offer to the Governor to assume leadership in the study of all matters relating to the need for, the development and the operation of an approved medical school and be it further

Resolved, that The Medical Society of New Jersey hereby propose to the Governor the establishment of a representative study committee and recommend to him that it be composed of 16 members to be appointed as follows: (1) that The Medical Society designate four of its members; (2) that The Medical Society invite Rutgers University to appoint four additional members; and (3) that The Medical Society request the Governor of New Jersey to appoint eight additional members from among leading lay citizens, and be it further

Resolved, that this Survey Committee shall be commissioned by him to investigate and study the requirements for successful completion of this project, and, upon completion of its study, it shall make known its recommendations to the Governor and the Legislature.

7. We approved a resolution by Dr. S. Emlen Stokes of Burlington County, requesting The Medical Society of New Jersey to express its appreciation to Senator H. Alexander Smith of New Jersey for his statesmanlike approach to the problem of compulsory health insurance in initiating the study of this subject published by the Brookings Institution.

8. Unanimous approval was given to the report of the Honorary Membership Committee nominating for Honorary Membership in The Medical Society of New Jersey Mr. William H. MacDonald, Chief, Local Health Division, New Jersey State Department of Health, in recognition and appreciation of his many years of assistance to and cooperation with the State Society.

9. A resolution advocating that The Medical Society of New Jersey urgently request the Legislature and Governor to enact S-148 as an essential step in providing modern high quality health protection to the people of New Jersey, was approved as presented.

10. The following nominations for Emeritus Membership presented by the Board of Trustees were unanimously approved:

Dr. William Flitcroft (Passaic County)
Dr. Clara K. Bartlett (Atlantic County)
Dr. Henry E. Woelfle (Hudson County)
Dr. J. Phillip Stout (Hudson County)

Dr. George H. Sexsmith (Hudson County)
Dr. Samuel Selinger (Hudson County)
Dr. James H. Rosecrans (Hudson County)
Dr. Wallace Pyle (Hudson County)
Dr. Benjamin Oider (Hudson County)
Dr. Thomas D. Keegan (Hudson County)
Dr. Hugo Gille (Hudson County)
Dr. John Connell (Hudson County)
Dr. David R. Atwell (Hudson County)

It is recommended that these Emeritus Members be nominated to the A.M.A. for affiliate membership.

11. Your Committee considered the resolution on Senate Bill 23 and the disposition of the State Board of Medical Examiners and unanimously approved the resolution in an amended form as follows:

Whereas, The Medical Society of New Jersey is rightly proud of the 58 year record of the New Jersey State Board of Medical Examiners in the elevation of standards of medical education and practice in this state, and

Whereas, The Medical Society of New Jersey has recommended, sponsored and worked for every progressive legislative enactment to elevate the standards of medical licensure and to support or further the work of the State Board of Medical Examiners, and

Whereas, The Medical Society of New Jersey believes that it is essential to insure that the State Board of Medical Examiners be kept free of political entanglement or interference in its vital function of protecting the public welfare in matters of medical practice, and

Whereas, The State Administration has proposed, in Senate Bill No. 23, to place the State Board of Medical Examiners, together with other professional licensing boards, under the supervision and control of the Secretary of State in an expanded Department of State, and

Whereas, this would effectively destroy the integrity and autonomy of these professional boards by subjecting the State Board of Medical Examiners to the domination of an officer not qualified by training to so function, and

Whereas, the disposition of the State Board of Medical Examiners, and its companion boards, as proposed in S-23 cannot be justified on the grounds of efficiency, economy or logic, and

Whereas, eleven of the professions * represented in eight of the examining boards have unanimously protested this proposal, and unanimously recommended that these boards be placed together in a separate principal Department of Professional Boards, therefore be it

Resolved, by The Medical Society of New Jersey, in 182nd Annual Meeting assembled, that we hereby make known our unalterable opposition to that portion of S-23 and that we oppose it with all the influence at our command; that we condemn the proposal to subject the State Board of Medical Examiners to the supervision and control of a governmental agency operated by a non-professional officer of the state; that we emphasize the fundamental necessity, in the public interest, of maintaining the professional integrity and the administrative autonomy of the State Board of Medical Examiners and comparable professional boards; that we reiterate our well considered alternative proposal for a separate Department of Professional Boards; and that we urgently solicit the support of all other agencies and persons concerned with the maintenance of standards of medical licensure in New Jersey in defeating the dangerous and insupportable principles embodied in this portion of S-23; and be it further

Resolved, that copies of this resolution be sent to the Governor, to all members of the State Legislature, to the press, and to all cooperating agencies in the field of public health and welfare.

12. This Committee considered a resolution urging increased life insurance examination fees and unanimously approved the resolution in an amended form as follows:

Resolved, that The Medical Society of New Jersey, in meeting assembled, go on record as approving an increase in the medical fees for regular life insurance examinations to $10, with all other medical insurance fees to be increased in like proportion, and be it further

Resolved, that the Delegates of this Society to the A.M.A. be instructed to try to have the A.M.A. take action consistent with this resolution.

SECRETARY BUTLER: With the exception of Paragraph Number 4, "I move the adoption of the entire report of the Reference Committee on Resolutions and Memorials. Samuel A. Cosgrove, Chairman."

(The motion was seconded and carried.)

PRESIDENT SCHAAF: Thank you, Dr. Butler, and I hope you will thank Dr. Cosgrove for the untiring effort he put into this report. At last year's Annual Meeting, there was a first reading of a proposed change in the Constitution, which requires second reading for adoption this date. It is Section VII, Emeritus Membership, and reads as follows:

"The Emeritus Membership group shall include physicians who have been members in good standing of a component county society for at least twenty years and who, by reason of age or infirmity, have retired from the active practice of medicine, or members of the Society who have been disabled by reason of military service. They shall have all the privileges of membership except the right to vote and hold office, but their respective component Society shall not be assessed for such members, provided they are carried as Emeritus Members in their

* Architects, chiropodists, doctors of medicine, dentists, veterinarians, public accountants, nurses, pharmacists, optometrists, chiropractors and osteopaths.

component societies. The Emeritus Members shall not be included in the membership of a component county society when computing the number of delegates that such society is entitled to."

Dr. Herschel S. Murphy: In Union County we were in receipt of a letter asking that the word "totally" be put before the word "disabled". We thought it would clarify this matter a little bit. I realize that there is a little footnote to that report, but we feel that there should be in the Constitution and By-Laws the words "totally disabled" because the man who is an emeritus member is unable to practice and we feel that it would be nice to have that word "totally" in there.

President Schaaf: Dr. Murphy, I think that your Society was notified that we ought to adopt this as written this year and then propose to change it by inserting the word "totally" next year; otherwise it will be two or three years before this change can be effective. It is up to the county societies to decide when a man is disabled as a result of military service. The first requirement is that he be retired and the second is that he be disabled due to military service. It is up to the component society to decide whether a man is totally or not totally disabled. We could reword this amendment next year, but most of the societies want this implemented now to save some money, and that is quite natural. Any further discussion?

A motion to approve the amendment was made, seconded, carried and the amendment was declared in effect.

Dr. Haggerty: Section 10 of the Report of the Reference Committee on Constitution and By-Laws, offered us a list of emeritus members. But at the time we approved that list, we officially had no such classification as an emeritus member. That was created by the vote just concluded. In order to make it official, let us now vote on the proposed list.

President Schaaf: They are voted in as Emeritus Members. What happened was this, the proposal I just read should have come up as part of the Constitution and By-Laws report. Unfortunately it was omitted by me and in order to validate this I had to put it in out of order; had this action been taken in its proper order this motion would have been all right. They are listed as Emeritus Members under this provision of the Constitution, so it is all right, I think.

It is one of the little slips with the countless details we have. If nothing worse than that happens, I am going to be very happy. That is my fault because I thought of it and then didn't bring it up.

I now call on Dr. Murphy for a report of Reference Committee B.

Dr. Murphy: Our Reference Committee, at a well-attended meeting, considered the reports of the treasurer, and of the publication and finance and budget committees and of such other matters as came within their jurisdictions.

The treasurer's report was presented to our Committee as of April 23, 1948. The Committee approves the report and wishes to commend Dr. Young on the splendid job which he has done. However, the cash reserve of approximately $22,000 seems to our Committee to be inadequate to allow a safe margin for emergencies and we feel this fund should be gradually increased so that we may have a more adequate reserve.

It is recommended that in the report of the treasurer presented at the Annual Meeting, a more true and adequate picture be presented by separating the accounts of the fiscal from the calendar year.

The report of the finance and budget committee was carefully examined and discussed item by item. The budget for 1948-49, a total of $95,599, as presented by Dr. Allman's committee was approved. The finance and budget committee recommends that the dues for 1949 be increased. Our Committee considered this matter and felt that since it will take approximately $23.00 per member to carry our proposed budget and in view of the fact that a special cash reserve for emergencies should be set up, we recommend that the dues for 1949 be $24.00 per member and that $5000 of the dues to be raised be set aside as a special reserve fund. We wish to commend Dr. Allman and his committee for their very excellent work.

The report of the publication committee, as presented by Dr. Henry C. Barkhorn, was studied and we wish to approve the report. We feel that Dr. Barkhorn, Dr. Henry A. Davidson, the editor, and Mrs. Armstrong, the assistant editor, should all be commended for the good job which they are doing.

Perhaps I should explain what we meant by calling on the treasurer to give separate accounts for the fiscal and calendar year. You gentlemen were very kind to us today; we came in with a good deal of trepidation, asking you to increase the dues. We felt you could get a better picture if you could see just how much you had and needed—and this would be made more vivid if the fiscal and calendar year accounts were presented separately. This way it looks as if we had a cash reserve of $200,000, whereas by July 1, it will be only $22,000. If the treasurer could have the authority of this House of Delegates to break down his report into more completely detailed items, it would be more realistic and give us all a truer picture. We ask the approval of the House for this entire report and I so move.

The motion was seconded and carried.

PRESIDENT SCHAAF: I now call on Dr. Collins to read the report of Reference Committee C.

DR. LOUIS K. COLLINS: The Committee met to consider the reports of the Medical Service Administration, the Committee on the Study of Medical Care, the Veterans Liaison Committee, the Military Service Committee and The Medical-Surgical Plan.

We approve of the report of the Medical Service Administration and make the following recommendations: Let it be called to the attention of the county societies that a state-wide plan has been arranged for the control of payment for services rendered clients of the Old Age Assistance Board. The clients may be reimbursed by the Old Age Assistance Board upon presentation of a receipted bill from the physician. In the past in some counties, a uniform allowance was made to the client each month for medical care, and no additional monies were available for severe illness.

A more liberal fee schedule has been arranged with the Board of Child Welfare. Both of these problems were studied by the Medical Service Administration and recommendations made to the Board of Trustees. This Committee recommends that these two matters and the approach on a county level be brought to the attention of all members of the State Society.

The next problem regards remuneration of physicians for services rendered clients of the Crippled Children Commission. No action could be taken, since it is stated that recommendations were submitted to the Board of Trustees, but these recommendations were not described in the report at hand. We suggest that reference be made to the fee schedule of the Crippled Children Commission of Washington, D. C., and recommend that Dr. Scott meet with the Crippled Children Committee of the Society in order to work out a solution to the problem.

This Committee approves of the report of the Medical-Surgical Plan, and also approves of the proposed changes in the Medical-Surgical Plan as outlined in the Supplementary Report of April 1948.

It has been proposed that Blue Cross Groups and Associated Medical Care Plans merge and form a national insurance company to promote sales of both plans nationally. This move is regarded as domination, one that would practically eliminate both the New Jersey Hospital Plan and the Medical-Surgical Plan, and does not impress the Committee with favor. We recommend that the House of Delegates disapprove the proposed merger. It is further recommended that a representative be present at Chicago on June 19, 1948, at the meeting of the American Medical Association Council on Medical Service, and that the views of the members of The Medical Society of New Jersey be expressed on the above matter.

Dr. Asher Yaguda appeared before the Committee with a desire to know what report was obtained from a "special committee to consider the inclusion of specialty medical service, i. e., laboratory, radiology, pathology, in Blue Cross contracts". Having no knowledge of this matter, the Committee recommends that this matter be brought before the Board of Trustees for further investigation.

We recommend approval of the report of the Committee on the Study of Medical Care. This is a very comprehensive report and has received many favorable comments from the press since publication in the April JOURNAL. Dr. Scott and his committee are to be heartily commended.

This Committee recommends approval of the report of the Veterans Liaison Committee.

This Committee recommends approval of the report of The Military Service Committee.

We also recommend that through THE JOURNAL and the component county societies, notice be made of the need of the regular Army for physicians and the opportunities and many inducements offered by the Army Medical Corps.

We further recommend that the Military Service Committee meet at an early date to establish policies and proposals in the face of reestablishment of selective service with the possibility of induction of physicians.

Each section of this report was separately voted upon, and each was approved by the House of Delegates. On motion of Dr. Collins the House also adopted an instruction to the Subcommittee on Public Relations to disseminate throughout the state the report of the Committee on the Study of Medical Care which begins on page 167 of the April 1948 issue of THE JOURNAL of The Medical Society of New Jersey. The following resolution of the Veterans Liaison Committee, which had been approved by Reference Committee C, was also adopted:

Whereas, it has been called to the attention of individual members of this Committee that certain veterans suffering with service connected and non-service connected disabilities requiring hospitalization are experiencing difficulty in obtaining admission to hospitals, and

Whereas, this Committee has a sincere interest in the welfare of the veteran and in his efforts to obtain adequate medical care, therefore be it

Resolved, that efforts be made to assist these veterans by instructing them to make contact with their respective county society committee through any physician who will inform them of the name of the secretary of the county society, who, in turn, will make contact with the proper member of the county committee which will make every effort to assist such veterans, and be it further

Resolved, that this effort on the part of this committee be given publicity through the press and through all service organizations and health agencies which may know of such cases among veterans.

PRESIDENT SCHAAF: We will now hear from Dr. Olpp, speaking for Reference Committee D.

DR. JOHN L. OLPP: Reference Committee D met and considered the reports of the following: Post-Graduate Education Committee, Medical Defense and Insurance Committee, Advisory Committee to the Woman's Auxiliary, and State Board of Medical Examiners.

The Chairman of the Post-Graduate Education Committee was present and explained the "Rutgers Plan". We commend Dr. Decker and his committee for the excellent work they have done. The suggested changes in the organization of this committee are endorsed.

The form acknowledging the risks of X-ray treatment, appended to the supplemental report of the Committee on Medical Defense and Insurance, was accepted with the proviso that the use of such a form be left to the discretion of the individual physicians involved.

Dr. Dodd and the members of the Advisory Committee to the Woman's Auxiliary are to be congratulated for their efforts in behalf of the auxiliary. Its ten-point program is ambitious and commendable.

It is hoped that the splendid work of the State Board of Medical Examiners will continue in the future, as in the past.

We move, Mr. President, the adoption of the entire report.

The motion was seconded and passed.

PRESIDENT SCHAAF: Dr. Schretzmann will give us the report of Reference Committee E.

DR. RUDOLPH C. SCHRETZMANN: Following are the actions of Reference Committee E:

(1) The report of the Subcommittee on Legislation and its supplemental report were read and the Committee recommends their adoption. Also the Committee recommends that our delegates to the American Medical Association present resolutions calling upon the American Medical Association to oppose grants-in-aid to the states for health purposes unless such states are able to demonstrate a need for federal financial assistance.

(2) The recommendation of the Welfare Committee with respect to medical attention at construction jobs was carefully reviewed and we advise that this be referred back to the Trustees for further study. Except for this item, we approve of all the recommendations of the Welfare Committee.

(3) The report and supplementary report of the New Jersey Health Congress are approved.

(4) The Public Relations report was read and the Committee recommends its adoption.

(5) The Public Health report was read and adoption recommended.

(6) The Medical Practice report was read and adoption recommended.

(7) The reports of the Public Health Advisory Committees on Cancer Control, Cardiovascular Diseases, Child Health, Conservation of Vision and Hearing, Crippled Children, Maternal Welfare, Mental Hygiene, Nutrition, School Health, Tropical Diseases, Tuberculosis, and Venereal Disease Control were all read and considered and their adoption recommended.

(8) Reports of the Medical Practice Advisory Committees on Anesthesiology, Contract Practice, Hospital Relationships, Industrial Health and Hygiene, Laboratory Medicine, Medical Care of the Indigent, Nursing and Nursing Education, Pharmaceutical Problems, Physical Medicine, Radiology, and Workmen's Compensation were all read and the Committee recommends their adoption as printed in THE JOURNAL.

(9) The Committee also considered the controversial problem involving the ruling by the Crippled Children Commission which requires that a physician be a diplomate of the American Board of Orthopedic Surgery before he is allowed to sign requests for prosthetic appliances for clients of the Commission, because of a federal ruling governing the use of federal funds available to the Commission. Cognizance was taken of the objections from the Essex County Medical Society and the Committee felt that the practice was unjust and that if possible should be modified.

The Committee recommends, therefore, that we ask the federal Commission to permit all Fellows of the American College of Surgeons to sign requests for prosthetic appliances as well as diplomates of the Board of Orthepedic Surgery.

The Committee recommends that the New Jersey delegates to the American Medical Association present a resolution requesting the federal government, through the A.M.A., to allow all Fellows of the American College of Surgeons to sign requests for prosthetic appliances which are paid for by federal funds.

Each item of this report was separately considered by the House of Delegates and, on motion, each was approved, and on further motion the report, as a whole, was approved.

PRESIDENT SCHAAF: An important matter has come up since the first session of the House of Delegates. It involves threatened legislation which would be detrimental to the welfare of medical practice in the state. It involves Senate Bill 171, the Optometrical Bill, and we have here a resolution drawn up by the Advisory Committee on Conservation of Vision, the Subcommittee on Legislation, and numerous ophthalmologists, which they offer to the House of Delegates for consideration and approval; and I therefore ask for a motion to suspend the rules to hear this resolution.

Motion was made and seconded to suspend the rules.

PRESIDENT SCHAAF: No opposition? We will operate under suspension of the rules, and I ask Dr. Sherman to come forward and present the resolution.

DR. SHERMAN: As our President has told you, this bill, now before the Legislature, known as Substitute for Senate Bill 171, the so-called Optometrical Bill, is giving the Advisory Committee on Conservation of Vision and the Committee on Legislation considerable trouble. It is certainly detrimental to the best interests of the public and the profession and that is why we are offering the following resolution:

Whereas, Committee Substitute for Senate Bill No. 171 proposes for the first time in the history of New Jersey to make a vocation or occupation "a learned profession", and

Whereas, optometry is a mechanical art but not a learned profession comparable to law, medicine and theology, and

Whereas, the honor and nobility of the "learned profession" is not a mantle one places upon his own shoulders, but is gained by public recognition, the result of achievement and attainment by honor and respect, and

Whereas, Section VII of this bill attempts to take away from the court the power to determine the qualifications of an optometrist to testify as an expert, and

Whereas, a further provision of this Section which requires certificates issued by optometrists to be accepted as qualified evidence, deprives a party of his right to examine their qualifications, deprives the judge and the jury of personal observation of witnesses and their manner of testifying, both of which are highly important in deciding as to the credibility and weight of the testimony, and

Whereas, there is no statute in this state dealing with any profession which incorporates such a provision as this or one comparable thereto, and

Whereas, the balance of Section VII requiring state, county and municipal departments and agencies to accept services of registered optometrists, represents a direct attempt in a new and different way to foster and stimulate business through legislation, rather than through merit, and

Whereas, the use of the words "on a parity with any other person authorized by law to render similar professional services when such services are needed, and shall pay for such services in the same way as other professions may be paid for similar services" is an indirect attempt to place optometrists through legislation on a par with the learned professions, and

Whereas, it is a sad commentary on any calling that recognition and respectability which should be acquired through reputation and merit is to be acquired by legislation, therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey in regular session, April 29, 1948, hereby records its opposition to Senate Bill No. 171 and urges its rejection by the New Jersey Legislature, and be it further

Resolved, that copies of this Resolution be forwarded to all members of the House of Assembly.

On motion made, seconded and passed this resolution was adopted.

DR. SHERMAN: Because of the emergency of this matter, our Committee on Legislation and the Advisory Committee on Conservation of Vision, request that the House of Delegates authorize the expense of addressographing and mailing this resolution to four hundred interested individuals, such as ophthalmologists, opticians, legislators, and so forth.

PRESIDENT SCHAAF: Moved and seconded that this circularization of the resolution be made to approximately four hundred individuals. Those in favor indicate by saying "aye"; those opposed, by saying "No". The motion is passed. Now Dr. Hollingsworth will give his committee's report.

DR. HOLLINGSWORTH: This is the report of the Reference Committee on Miscellaneous Business. We considered and approved the reports of the Annual Meeting Committee, the Subcommittee on Scientific Program, and the Subcommittee on Scientific Exhibits. We commend them for the excellent results of their work and congratulate them and the executive office and staff for the smoothness with which the details of the program have geared together.

We also considered a communication from the Interim Committee of the New Jersey Housing Council. This communication was read to the House earlier (see page 16 these TRANSACTIONS). It asks us to give support to the federal housing bill—the Taft-Ellender-Wagner bill, and to the New Jersey bills A-188 and A-189, and asks us further to send a representative to the committee.

While we are in favor of the principle of low cost housing, the methods of achieving it are not primarily medical. As doctors, we are not qualified to evaluate the various legislative proposals for achieving this end. We recommend that no action be taken on this communication.

The following resolution from the Subcommittee on Public Health was submitted to us by the Board of Trustees without recommendation:

"*Whereas,* the American Medical Association held the first national school health conference in October, 1947, and included in its third rural health conference in February, 1948, the health and medical care problems of rural children and

"*Whereas,* state and county medical societies, having child health committees and programs, have need of guidance and assistance at national levels for their child health programs by having a specific bureau of the American Medical Association responsible for children,

"Therefore Be It Resolved, that The Medical Society of New Jersey request that the House of Delegates of the American Medical Association add the words 'Child Health' to the title of the present Bureau of Health Education, to read 'The Bureau of Child Health and Health Education', in order that this excellent and helpful bureau may definitely be regarded by county and state medical societies as the coordinating center in the Association for the study and evaluation of the many types of child health and medical care programs being evolved by governmental, medical, and voluntary agencies in this country."

We recommend that it be approved.

Each section of the report was acted on separately, and each was, on motion, approved; and then the entire report of the Reference Committee on Miscellaneous Business was approved. The President then called on Dr. Lewis to give the census.

Dr. Lewis: The last minute census: 272 Delegates, 754 members, with a total of 1873, which is the largest, by about 400, that we have ever had.

President Schaaf: Excellent. Thank you, Dr. Lewis.

Dr. Lewis: More or less allied to this subject, may I have consent to make a few remarks, about two minutes' worth, and a request?

President Schaaf: May I have unanimous consent to hear Dr. Lewis?

(Unanimous consent was given.)

Dr. Lewis: When the House opened, there were just barely a hundred present. We have acted upon a great many matters this afternoon with a bare quorum present. The action taken involves monies to physicians that will amount to something about a million dollars a year.

In view of the fact that we have now four days instead of three, I would recommend that the last meeting, the actual voting meeting of the House of Delegates, be changed to Wednesday morning or Wednesday afternoon.

We have this same situation every year with only a handful of the Delegates waiting to pass judgment on the most important matters. I feel that strongly because in recommending the supplementary report of the Medical-Surgical Plan you have taken a serious step. I attended the Reference Committee meeting. There were two men outside of members of our group and the Reference Committee present. There were barely a hundred men here when the proposition was introduced and not much over a quorum has come to a final decision.

I think in some way it should be made possible that we have a larger attendance at the meeting of the House of Delegates where final action is taken on so many vital and important matters.

President Schaaf: A motion to refer that to the Board of Trustees is in order.

(Motion was made, seconded and passed that the matter be referred to the Board of Trustees.)

President Schaaf: This suggestion will be referred to the Board of Trustees for consideration. Is there any unfinished business, Mrs. Madden?

Mrs. Madden: Nothing at all.

President Schaaf: I am now down to the last half mile or half foot, I don't know which, but before presenting the incoming President, I would like to express to the House of Delegates and to The Medical Society of New Jersey my very deep appreciation of the opportunity which was given me to serve you.

We have had, I think, a very harmonious and very active administration in which every committee and every individual put forth their best efforts to execute the program of the Society, and to each and all of them I am eternally grateful.

Now I am going to introduce the incoming President by proxy, but before I do I am going to say that he has given me the most loyal support, that I have enjoyed knowing him and working with him, and that I offer him here and now my wholehearted cooperation in anything which I can do on a personal basis. Being out of office, I won't be able to do much officially, but personally I will be willing and able to do anything for him.

Some years ago when Dr. Carrington was President he was one of the best presiding officers whom it has ever been my fortune to hear. He initiated the plan of having a member of the home county of the incoming President make the presentation. At that time it fell to my lot to present Dr. Hawkes and I was very happy to do it and he was very happy to have me. So I discussed it with Dr. Hornberger. He thought it was an excellent idea and I offered the selection of any member of his society whom he might wish and with the gentle suggestion that perhaps Dr. Bray would be the ideal man for it. I have heard Dr. Bray speak on several occasions; he speaks beautifully. So Dr. Hornberger concurred in my selection, and I am therefore going to ask Dr. Bray to come forward and tell us of the friendly and human side of our incoming President. Dr. Bray.

Dr. William Bray: Mr. President, Members of the House of Delegates: To me this is a singular pleasure, privilege and honor. When I first went to Burlington County a few

years ago and became a member of the Burlington County Medical Society, I was not long in learning that Dr. Hornberger was the bulwark of that organization. The Society had done everything they could to honor him; and twofold, for they had elected him twice to the presidency of that organization.

He went into state society work and for sixteen years he served as a member of the Board of Trustees. During that time he also served as the chairman of the Welfare Committee.

Dr. Hornberger was playing on the State team—and I think that you must remember that cooperation in the State Society as well as cooperation on the football field are comparable: cooperation for success. While he was playing on the State team he wasn't one of those flashy backs that you saw cutting down the field for a touchdown. He wasn't skirting the ends, but he was playing up in the line. He was playing a line position, one of those fellows, you know, that after the man goes through you look back and you see his face sort of down in the mud, probably a foot on his neck or something like that. You know, those fellows make possible, through their cooperation, the work of the halfbacks.

So many times the linemen do not receive honors, but today, gentlemen, we are going to honor a man from the line. Today I am going to present as our President my friend, a man who knows what friendship is. I am going to present a man as our President who has grim determination, who has utmost sincerity and who is willing now to sacrifice everything for the success of this Society.

It gives me the greatest of pleasure to present my friend from Roebling, New Jersey, in the County of Burlington, your President, Dr. J. Howard Hornberger.

(The Delegates arose and applauded.)

DR. HORNBERGER: Thank you, Dr. Bray.

I think with such an introduction it might be well to go right into the first scrimmage of the year.

A number of years ago during the Annual Meeting, one of our colleagues and I casually mentioned that it might be nice to have a general practitioner as President. Little did we dream that someday it would be I and it is quite possible that you will even less long remember that I have been here. This high honor is given to a relatively few men. With it there goes an equally high responsibility. In the spirit of sincere humility I accept them both. It is difficult to follow and attempt to emulate a man as able and distinguished as my predecessor, Dr. Schaaf. This I know only too well by reason of association. I am also constantly and repeatedly reminded of it as I travel throughout the state. Fortunately, however, there is also an easier side. The fundamental ideals and basic philosophy of organized medicine remain constant through changing administrations and the projects not concluded carry over into the next year. It is obvious therefore that with Dr. Schaaf having so thoroughly laid the groundwork these ideas will be carried forward of their own momentum.

Great strides have been made during the past year. The Veterans Care Program is largely stabilized, the threat of federal legislation unfavorable to the best interest of medical practice and public health looms a little less large on the horizon. However, let us not become apathetic lest our opponents strike a mortal blow while we are at ease. Remember eternal vigilance is the price of safety. The Subcommittee on Public Relations with the able assistance of our Executive Officer has established a rock firm foundation on which we hope to start a superstructure which when completed through the years and administrations to come will stand as an eternal monument to the forethought of organized medicine in New Jersey. Our work in the field of Public Health must be carried on as is befitting Councilors in this field. The laity are constantly challenging us on the cancer problem. Management and Labor may well look to us for guidance in the industrial health and hygienic fields. Venereal disease problems, like the poor, are with us always. Remarkable as have been the strides in maternal and child health and the resulting decrease in mortality we are still confronted with some doubting Thomases who wonder why perfection cannot be attained in a process which is considered physiological. The problem of disseminating the Gospel of improving the health program in schools has been assumed by the Woman's Auxiliary and we may be assured of a job well done.

We reaffirm the principle that every man, woman and child in New Jersey is entitled to and will receive adequate medical care. We stress particularly the extension of these facilities to the rural areas of our great state. To these and other problems as yet unforseen which may arise we pledge this administration and promise unselfishly what God given attributes we may possess shall be devoted to this end. In this we bespeak for ourselves and for your Society your sincere cooperation. Together we must not fail.

Committees have been and are being appointed. After consultation with officers and key men of the component societies we have and shall endeavor to head these committees with men eminent in their field, supported by those who have the best interests of organized medicine at heart and who are able and willing to serve. Special emphasis has been placed on the younger men in order that they may be trained to be the leaders of the tomorrow which is sure to come. It is obvious that all who are qualified and willing to serve cannot be appointed. Many are called but few are chosen. Called or chosen this is your Society and if each individual member will contribute to the extent of his ability and the limit of his time there can be only one answer. New Jersey will continue to lead in progressive medical thought in the United States and

implemented by action will go on to ever greater heights. I thank you.

PAST-PRESIDENT SCHAAF: There is another person who will suffer through the presidency, and I assure you she will suffer through it. She is here, and I should like to present Mrs. Hornberger.

(Mrs. Hornberger took a bow while the Delegates applauded.)

DR. ALLMAN: Perhaps we have overlooked section III of Article VIII of our Constitution which states that the time and place of the Annual Meeting are fixed by the House of Delegates.

I wish to extend to this House of Delegates a very cordial invitation from the Medical Society of Atlantic County for The Medical Society of New Jersey to hold its one hundred eighty-third Annual Meeting in Atlantic City. I see no reason why we should not accept that invitation and I move you Mr. President, that this House of Delegates go on record as holding its one hundred eighty-third Annual Session in the Convention City. (Applause.)

PAST-PRESIDENT SCHAAF: Those in favor of the motion will indicate by saying "aye"; those opposed? The motion is carried.

PAST-PRESIDENT SCHAAF: Now I take pleasure in introducing our new Second Vice-President, Dr. Sigurd Johnsen.

DR. SIGURD JOHNSEN: I thank you from the bottom of my heart for the honor you have bestowed in nominating and electing me to the office of Second Vice-President, and I pledge myself to do all I can to continue the excellent work that we have seen done in the past year, and we hope that there will be continued the harmonious program that has been developed here.

PAST-PRESIDENT SCHAAF: Thank you, Dr. Johnsen.

We have a new Trustee who succeeded Dr. Johnsen when he left the lower ranks. Dr. Larry Evans. (Applause.)

DR. LAWRENCE EVANS: Mr. President, I feel very much the same as Sigurd Johnsen. I know very well what he will accomplish in his new office, and I will try to do the best I can to fill the vacancy in the Board of Trustees which he has made.

(Upon motion duly made, seconded and carried, the meeting then adjourned *sine die* at 3:45 p. m.)

PRESIDENTIAL ADDRESS

THE PRINCIPLES OF THE MEDICAL SOCIETY OF NEW JERSEY

Address of the Retiring President
Royal A. Schaaf, M.D.

The retiring presidential address has long been one of the features of our Annual Meeting. Each president has presented the topic which at the time seemed most pertinent or appropriate. Many of these addresses display great erudition. Their subjects have ranged from philosophy to politics, from education to science; their styles have varied from the solemn to the whimsical.

It seems to me that the retiring president should attempt to leave with the Society a summary of the ideas he has gained from his years of official service, with the hope that his successors may find something of value to aid them in dealing with the problems incident to their administrations. With this thought in mind I shall attempt to present the guiding principles of the Society which have been evolved from year to year, to meet problems as they arose. They form the basis of our present philosophy and provide the rationale of our actions.

Prior to 1890, this Society was entirely a scientific, educational and to some extent a social body. By 1900, with the increase in our knowledge of the etiology and prevention of communicable diseases and the advent of organized health projects, our Society became the agency for the implementation of group health programs—we became a public health body. By 1910, with the increasing number of legislative bills having public health or medical practice implications such as workmen's compensation, osteopathy, licensure, etc., we found it necessary to interest ourselves actively in the field of legislation. By 1920, with the development of the "social conscience" it became apparent that organized medicine had a direct responsibility at least for the health, if not for the economic, aspects of social welfare. We then began active participation in the programs of welfare agencies. During the depression which began in 1929, the problem of the distribution of medical care assumed increasing size and importance. Prior to that year, discussion of medical economics was tabooed at our society meetings; but with the impending threat of the socialization of medicine, it became our number one interest; and much of our Society activity since that time has revolved on this axis. It became necessary for us to evolve plans for the distribution of medical care to all groups of the population; to present our views to the general public; to debate the merits and demerits of socialized versus private medical care and to secure and retain for organized medicine the good will of the general public. Thus, we became an economic body, and thus entered the field of public relations.

With the threat of war in 1940 and with its outbreak in 1941, organized medicine assumed responsibility for the procurement and assignment of medical officers for the armed forces—and when the cessation of hostilities came, we proposed and implemented plans for the medical care of veterans. Because of our demonstrated ability to cope efficiently with medical problems requiring coordinated action and because we have convinced the public of the sincerity of our interest in the public welfare, the New Jersey Division of the American Cancer Society has placed in our hands complete control of the expenditure of money for the establishment and operation of all medical facilities which the Cancer Society now provides in this state.

Thus in less than sixty years, our functions have changed from those of a simple professional body to those of a complex organization with accepted responsibilities, in public health, legislation, social welfare, public education in health matters, distribution of medical care, public relations and other fields. We now have many committees and subcommittees each devoted to special phases of these major subdivisions of our work. In the transition stages of our development it became necessary to formulate and expound new principles to meet the problems as they arose. Our leaders felt their way along cautiously, carefully thinking out the factors in each problem. Before embarking on a course of action in a new field of activity, they clearly enunciated certain fundamental principles on which to base their recommendations and actions. We now have a well established code of principles which reflects our collective judgment and experience. These basic principles furnish points of departure for our work in any field of medical society activity old or new.

The principles may be briefly stated as follows:

PUBLIC HEALTH

1. Individual and collective cooperation with established public health agencies, municipal, county and state, for the prevention, diagnosis, treatment and isolation of communicable diseases.

2. Institution and enforcement of adequate quarantine regulations.

3. Education of the public in regard to the general aspects of communicable diseases.

4. Active participation in immunization programs.

5. Strict compliance with rules for the reporting of communicable and other diseases required by law or ordinance.

6. Accurate completion and registration of birth and death certificates.

LEGISLATION

7. Endorsement and support of bills with direct or indirect health implications which serve the public interest.

8. Opposition to all measures which do not in our opinion serve that interest.

9. Introduction and support of proposed legislation to elevate the standards for medical licensure.

10. Opposition to all bills which would directly or indirectly lower these standards.

11. Endorsement of welfare legislation within the framework of the American social and economic pattern.

12. Support of voluntary medical care, hospital care and cash sickness benefits.

13. Opposition to compulsory medical, hospital and cash sickness benefit programs.

DISTRIBUTION OF MEDICAL CARE

14. Cooperation with and participation in the programs of public and recognized private welfare agencies whenever possible, assuming responsibility for the medical and health parts of such programs.

15. We endorse the principle that adequate medical care must be made available to every one regardless of his economic status, such care to be provided at a cost which the patient can afford to pay. We divide the population into four groups.

a. The affluent who need no financial help and whom we can disregard from the standpoint of the cost of medical and hospital care.

b. The great middle class who are self supporting except, perhaps, in catastrophic illness; who may or may not need financial help and for whom we advocate voluntary sickness insurance furnished by non-profit organizations operated and controlled by state medical societies.

c. The medically indigent who can provide food, clothing and shelter for themselves but whose income is inadequate to provide medical care.

d. And the indigent who are unable to provide all or any of the essentials of human welfare, namely, food, clothing, shelter and medical care. For the two last groups we advocate provision of medical service by subsidy from general tax funds on a local level.

16. Endorsement of non-profit voluntary hospital insurance plans.

17. Muncipal, county and/or state aid to the voluntary hospitals by the payment of the per diem cost for the care of indigent and medically indigent persons.

MEDICAL PRACTICE

18. Free choice of physician.

19. Payment to the physician on a fee for service basis.

20. Opposition to corporate practice of medicine in all forms particularly by hospitals.

21. Recognition of the so-called auxiliary services (a term which should be discarded) namely anesthesiology, roentgenology, clinical pathology and physiotherapy as medical specialties and integral parts of the practice of medicine.

The world has survived the most destructive war in history and it is now suffering from its aftermath. Throughout Europe and Asia there has been a volcanic, political, social and economic upheaval leaving death, destruction and demoralization in its wake. Although we in the United States have preserved our liberties and our institutions intact, we also have been profoundly affected in our political, social and economic thinking. Established practice in all professional branches is under attack, particularly that of medicine. Stormy days lie ahead for the doctor and for organized medicine but we need have little apprehension about the ultimate fate of our profession in this State if we adhere to our basic principles and continue on the course which we have charted.

GENERAL SESSION

Wednesday Afternoon, April 28, 1948

. . . . The General Session convened at two o'clock in the Viking Room, Haddon Hall. President Schaaf presiding. . . .

President Schaaf: This meeting will please be in order. The Medical Society of New Jersey has had a long history. It is the oldest such organization in the Western Hemisphere. It began in 1766. In the intervening years we have had many practitioners who have had local reputations and some have won national fame. But in the whole history of The Medical Society of New Jersey, only seven men have earned an international reputation. Four of them are deceased. One of the three still living is the speaker this afternoon. He is internationally known in the field of otolaryngology and has done more laryngectomies than any man alive. He has revolutionized the mortality of laryngectomy by his thorough preparation and his unusual after care. He is attending laryngologist at the Presbyterian Hospital in Newark and the City Hospital in Newark, and has several teaching positions. It is a great pleasure to introduce one of our members who has an international reputation. Dr. Henry B. Orton.

Dr. Henry B. Orton: I wish to thank Dr. Schaaf for his most gracious introduction. It is not often that an otolaryngologist addresses a general session, and I accept this compliment as an honor to the specialty I have the privilege of representing this afternoon.

Dr. Orton then delivered an illustrated, scientific essay on carcinoma of the laryngopharynx. The paper will be published in full in The Journal of The Medical Society of New Jersey.

President Schaaf: It is easy to see why Dr. Orton has an international reputation. This kind of surgery takes a daring, courageous, and supremely competent man. Surgeons come from Copenhagen and from Paris and elsewhere to see him do these operations. And I know he would be happy to have any of you visit him at his clinic at any time. He does two or three of these a week.

I now present one of our past presidents who has undertaken new and greater tasks. He has been doing many things, among them the development of the New Jersey chapter of the National Physicians Committee. He has been indefatigable in his efforts to develop that chapter and has obtained brilliant results. I present Dr. Londrigan.

Dr. Joseph Londrigan: It is indeed a pleasure to present the next speaker who, in my mind, has one of the greatest messages for the doctors, their wives, their families and for the ordinary citizens of every American community.

In 1911 the first panel in England was established and went into effect. On July 5, 1948, just 37 years later, the entire medical profession of England will be socialized even though 86 per cent of the doctors voted against it. It could happen here. We hope not.

In New Jersey we have 4,500 members of our Society, plus a few doctors who are not. Of that 4,500, some 900 are members of our team, the New Jersey chapter of the National Physicians Committee. Every member of the State Society should join our team, and that is the reason for the speaker whom I am about to introduce. He will give you the facts which should impel each member of The Medical Society of New Jersey to take his place on the team of the National Physicians Committee.

I have the pleasure of presenting to you Mr. Arthur Conrad, Associate Administrator of the National Physicians Committee.

Mr. Conrad delivered an interesting and challenging address on the menace of collectivism.

DINNER DANCE

April 28, 1948

Toastmaster Ulmer: Ladies and gentlemen: Speaking to The Medical Society of New Jersey I want to welcome you to a program of relaxation and physiology. Since the remnants of the remaining party have all about drifted in, I think we ought to get acquainted. I am going to present to you some very uncomfortable people to my right and left.

I first want to introduce to you the president-elect of the Woman's Auxiliary, Mrs. Robert B. Walker and her husband Dr. Walker, and believe me, he is going to see very little of his wife next year.

I want you to meet the president-elect of The Medical Society of New Jersey, Dr. J. Howard Hornberger and his wife Mrs. Hornberger.

I have a suggestion to make to Mrs. Hornberger. She is going to see very little of her husband. He is going to be away from home a great deal: days, even weeks, and when he does return home he will have always the same excuse, "Official business, dear. Official business". If at any time he stays away from home for more than a month, I would suggest that during this period if he never calls you and you never hear from him, and if you become disturbed about his absence I would suggest that you get in touch with our very efficient Mrs. Madden at the Executive Office, and believe me she will locate him, probably in some wild remote section of the state—perhaps in Hudson County—and believe me, Mrs. Hornberger, she will bring him back alive.

I am next going to present to you the wife of the guest speaker. There are some women who bask in the reflected glory of distinguished husbands. But here is a lady from Baltimore who has plenty of individual charm, Mrs. John C. Krantz.

Now I am going to introduce the bravest person in the world. She has lived with me many years and she knows me better than anybody else on earth. She hears me bellow around the house from morning till night. Then this evening of sheer enjoyment and delight she must sit and listen to me again: the wonder woman of the atomic age, my wife.

The president of the Woman's Auxiliary has had a busy year. She has attended many meetings of her auxiliaries throughout the state. They have had quite a few teas and several councils of war. Now that her administration is over she is going to a strange new place—her home, where she is doomed for an indefinite period of involuntary domestic servitude, Mrs. Lodovico Mancusi-Ungaro. (Applause.)

Mrs. Mancusi-Ungaro: Dr. Ulmer, Dr. Schaaf, distinguished guests, members of The Medical Society of New Jersey and of the Auxiliary, and friends: It is a privilege to welcome you all here this evening. The roll of hostess is one all my Auxiliary girls like to play.

We hope you have a wonderful time and we are so glad so many of you are here. Next year we hope we have to have Convention Hall. It is a great privilege to be here to pay honor to the leader of our Medical Society who has led us so beautifully this year, and his wife. Thank you all and I hope you have a grand time.

Toastmaster Ulmer: And here is Dr. Mancusi-Ungaro.

I understand that Dr. Mancusi-Ungaro threatened on several occasions to divorce his wife for desertion, but they are now reconciled and may they live happily ever after.

The Medical Society of New Jersey had a long list of presidents, many of them distinguished. However, it is not likely that any one of them exceeded in administrative ability the leader we have had this year. He really has had two administrations. Last year because of the illness of the then president he assumed most of the responsibilities of the office, and this year he carried on with experience and energy. We have been very proud of him and his excellent leadership. He possesses that unique triplet of talents: poise, personality and perspiration.

I am both honored and delighted to present to you the President of The Medical Society of New Jersey, Dr. Royal A. Schaaf.

Dr. Schaaf: Dr. Ulmer, guests and friends. I am sure there is another corpse in the church, and speaking of churches, the last assignment I had as a public relations man, if you will, was to speak to a fairly large congregation in a church last Sunday. It was quite a formal service and I was in the middle of the program. The master of ceremonies was very eloquent and gave me a build-up. Justice was nothing beside the build-up he gave me. I arose very embarrassed. I said I recognized that as the purest form of flattery, but I loved it, but I couldn't tell my usual stories. I went ahead and delivered some remarks and then the preacher followed me. He arose, after a most brilliant and eloquent introduction, and

he said, "Dr. Schaaf said he loved flattery, and so do I," and a great roar went up through the church.

I am not going to make a formal speech. I am happy to see so much conviviality. I have seen everything now. I have seen Jim Norton dance, and believe me it wasn't an old-fashioned waltz either.

What I would like to do, however, is to express appreciation for the many things that everybody has done. We have had a wonderful convention. I think it is the largest we have had by 300. The sections have been well attended and I am grateful to everybody who has participated in the program and particularly grateful to the chairman of the convention committee and his faithful workers. They have staged a wonderful meeting, and I express gratitude to Dr. Yaguda for the exhibits which he has put on, and to Dr. Clarke for the excellent sections which he has arranged. Particularly I am grateful to the office staff for their efficiency.

I am happy to see so many Essex County people. My whole surgical staff is here except one, who has to stay in Essex to take care of the home fires.

The commercial exhibitors tell us that this is the best convention that they attend next to the American Medical Association. This year we had to turn down 35 prospective exhibitors for lack of space. They tell us also that next to the American Medical Convention it is the best run convention that they attend, and that is due to the untiring efficiency, energy and intelligence of our own Edith Madden. Will you take a bow?

I am very grateful to the choristers for the effort and time they have spent. Many of them made a special trip down just to sing tonight and then they are going back home. I accept that as a most gracious tribute, and I want to thank everybody. (Applause.)

Toastmaster Ulmer: Deserving a place with Dr. Schaaf in New Jersey's Hall of Fame is his wife. She has been understanding and helpful. Perhaps no small measure of Dr. Schaaf's successful administration was due to the loyalty and fine spirit of his wife.

I am pleased to present to you a lovely lady, Mrs. Royal Schaaf.

Yesterday The Medical Society of New Jersey honored a fine practitioner of the state, bestowing on him the award of the outstanding general practitioner of New Jersey in the year 1948. He and his wife are here in the assembly now and I wish to present to you the outstanding general practitioner of 1948, Dr. and Mrs. Wolfe.

I am reminded just now of the man who was ill with heart disease. During his illness a telegram came to the home announcing that he had been the winner of the Irish sweepstakes and awarded $200,000. His wife was elated but hesitated to tell him the good news, fearing that it would precipitate a heart attack, so she asked his doctor. He said to her, "Now, don't tell him. Leave it all to me. I will take care of it. I will come over this evening. I will break the good news tactfully and if he has any reaction I will give him a stimulant hypo." At the appointed time the good doctor came and congratulated the wife on her extraordinary fortune, and together they went upstairs to the bedroom. Approaching the bedside the doctor said, "Well, Wilbur, how are you feeling tonight?"

"Not so well, doctor, had a bad day. Had a lot of pain around my heart, so short of breath and then too, doctor, I am getting worried. I have been sick so long. There has been so much expense."

"But," interrupted the doctor, "you won't have that to worry about very long." Then continued the doctor, "Say, Wilbur, I was just wondering today, have you ever gambled or speculated or taken chances?"

"Why rarely," said the patient. "Come to think of it, some time ago I did take a chance in the Irish sweepstakes, but I have forgotten all about it."

"That is very interesting," said the doctor. "Wouldn't it be wonderful if you had won?"

"But," answered the sick man, "don't taunt me. I have never had any luck in chances. It is ridiculous."

"But," persisted the doctor, "now just suppose you had won. What would you do if you had won the award of $200,000?"

"Well," said the patient thoughtfully, "I will tell you what I would do, doctor. You have been so wonderful to me, so attentive, so kind. You have saved my life. Do you know what I would do? If I won the $200,000 I would give you half." With that the doctor dropped dead.

Quite a few years ago this Society inaugurated a beautiful custom. It is that of making an annual award at this time to its retiring president.

I will now present to you Dr. Samuel Alexander who will officiate at this ceremony.

Dr. Alexander: Mr. Toastmaster, Dr. Schaaf, Mrs. Schaaf, invited guests, ladies and gentlemen: It has been the custom for many years to present to the retiring president of our Society a key. A key—symbolic of the end of an era during which time the president of

the Society gives his toil and sweat on behalf of the members of this organization and the people of our state at large. Also, it inaugurates the new era during which time the retiring president remains a Fellow, so that we may have the benefit of his judgment and experiences during his term as president.

And so, Dr. Schaaf, it is a great privilege to me personally and as a Fellow, to present you with this key.

Dr. Schaaf: I am very grateful to the Society for the key. I will treasure it all my life.

Dr. Alexander is sailing for Europe tomorrow at seven o'clock and he drove down especially to present the key, and I am very grateful to Dr. Alexander.

Toastmaster Ulmer: Witnessing this award makes me think of an event that occurred many years ago. My boy came home from school one day wearing a large, yellow paper medal pinned to his shirt by his teacher. I was proud of him. I thought perhaps that he had contributed something to the Einstein theory or had discovered a new logarithm, but upon inquiry I found that he had brushed his hair and washed his ears for a week.

The time has arrived now in our program when everybody relaxes except the guest speaker. He was born in Baltimore and graduated from the University of Maryland, Department of Pharmacy, at the age of twenty. He received many honors from his alma mater and he later became Professor of Pharmacology at the University of Maryland, School of Medicine. He has been secretary of the Revisions Committee of the United States Pharmacopoeia since 1940. There is a lot more I could tell you about him, but I am not one to reveal all.

He is a great sailor, having sailed catboats and sloops and other mysterious craft on the Chesapeake Bay.

He has recently been experimenting with anesthetics. He frequently subjects himself to the effects of a new anesthetic that he develops and then reports his sensations—rather recently, I think.

He can also qualify as a novelist, having written several books, none of which has yet been banned from the news-stands—not so bad. One of his recent books is called, "If Sugar Burns". I am not so sure whether this is a book for confectioners and bakers or a manual for diabetics.

After all, you want to hear him, not me; so I am pleased to present to you the Professor of Pharmacology at the University of Maryland. His subject is *The Simplicity to Wonder*. Dr. John C. Krantz, Jr.

Dr. Krantz: Mr. Toastmaster, President Schaaf, distinguished guests, members of The Medical Society of New Jersey. It is a pleasure to be here this evening and talk to you about *The Simplicity to Wonder,* and I know that you have been wondering up to now just what that topic stood for. When the chairman of your program committee asked me to speak this evening he permitted me to select a favorite topic. Despite the fact that there are many dangers involved when you allow one to use his favorite topic, I am reminded of the graduate of Yale University who had as his favorite topic his alma mater and on every occasion when he was called upon to speak he spoke about the advantages of graduating from that great northern institution. One time he took the letters of the word Yale: Y for the youth, A for their athletics, L for the loyalty and E for the energy of those supermen who graduated from Yale and to that theme, Mr. Toastmaster, he talked for two and one-half hours. Thinking he had done a perfectly splendid job he walked out through the audience with his shoulders squared and his head erect, only to hear someone naively remark, "I am very glad he didn't graduate from the Massachusetts Institute of Technology".

We have learned tonight from Dr. Ulmer that we are living in the atomic age and we have seen one of the wonders of the atomic age. The scientific spirit has captivated everyone, which calls to my attention the story which is told of the biologist who married into a perfectly good Baptist family from the eastern shore of Maryland. In due time, twins were born into the family. The father didn't frequent the church very often, but when the time came for these children to be baptized the biological father and the religious wife attended church. The pastor had pronounced the name of one child, and then the scientific spirit of the father got the better of him. He held up his hand and said, "Hold up on the other one and save it for a scientific control."

When Benjamin Franklin was in England the parliament was composed of three estates —the Lords Common, the Lords Noble and the Lords Temporal. Sir Edmund Burke pointing to the reporters in the gallery, the gentlemen of the press, referred to these men as the fourth estate, probably destined to play as great a part in the history of mankind as any of the other three. Burke was unmindful of the fact that there was in England in the person of Benjamin Franklin, a prototype, an exemplar of the new estate, the fifth estate, men of science, architects of progress who were

destined to remould the character of man's life upon this planet.

It is altogether fitting and proper that we should think together about some of these members of the fifth estate this evening, who have played an important role in human progress. Few indeed are those in any generation who by their scintillating intellects and indomitable curiosity have broken through the frontiers of scientific knowledge and achieved discovery—Discovery, "the increment of progress"—Discovery—"the differential coefficient of the curve of knowledge." I know of no better way to characterize these men than to say that "they have the simplicity to wonder, the ability to question, the power to generalize and the capacity to apply."

Lowell expressed the spirit and service of science in these inspiring lines:

> "New experiences teach new duties,
> Time makes ancient good uncouth,
> He must onward still and upward
> Who would keep abreast of truth."

Rudyard Kipling characterized that fine art of critical thinking when he penned,

> "I have six faithful, serving men
> They serve me till I die,
> Their names are who, and what, and when,
> And how, and where and why."

My story begins in 1664. Charles II sat on the throne of England. The reign of no other British monarch witnessed such an illustrious galaxy of Englishmen. To philosophy and history this era gave John Locke and Samuel Pepys: poetry was enriched by the advent of Milton and Dryden and the names of Issac Newton and Robert Boyle were inscribed upon the scroll of science. The architect, Christopher Wren, was contemporaneous with this distinguished group. Wren suggested to Boyle that if he could insert a quill into an animal's vein he could inject medicine or poison at will directly into the animal's circulation. Owing to the brilliance and resourcefulness of Wren, who at 24 was appointed Gresham Professor of Geometry at Oxford, Boyle was prompted to try the experiment. A dog was lashed to a table in the warden's dwelling at Wadham College. One of the superficial vessels of the leg was exposed and a quill inserted directly into the vessel and ligatured. By means of a syringe, an infusion of opium was injected. With bated breath the two investigators watched the animal slump into a deep narcosis. Inspired by the success of this experiment, the architect and chemist transfused blood from one dog to another. A new era in medicine was to be established—the quill became the precursor of the hypodermic needle which has made available as medicinal agents a host of substances which would otherwise be without therapeutic merit. In 1665 the experiments were precipitously interrupted. The plague in London had reached its peak. Wren was off to Paris. The flamboyant Gothic architecture captured the imagination of the sagacious young scientist. Paris was building and its contagion soon engrossed Wren. In 1666 London was razed to the ground by the great fire. Hardly had the ashes cooled when Wren returned to a new London. And thus this scientist became a distinguished architect. As one stands in old St. Paul's and reads the timeless epitaph. "If thou seek his monument, look about thee", you can feel the spirit of the genius of Wren, a man with the simplicity to wonder who gave to medicine the art of transfusion and the concept of the hollow hypodermic needle.

Servetus, the anatomist of the pulmonary circulation was burned at the stake in 1553 because he had made too many searching inquiries into religion with that maddening calm of the wholesome scientific question "And how do you know that?" The year is 1790, more than two centuries later—the scene is Paris—the thunder of the revolution shakes the earth. Yet in the quiet and calm of his laboratory Antoine Laurent Lavoisier is putting a great question to nature. He has been told when substances burn they lose a mysterious material called phlogiston. Lavoisier did not believe—he asked—how do you know that? "If phlogiston exists," said Lavoisier, "I shall get it and weigh it on the balance and compute it by mathematics. If I cannot weigh it or compute it by mathematics, it does not exist." And thus with this spirit of wholesome inquiry he showed that burning was not the dephlogistination of matter but a combining with oxygen. "And then what about breathing?" inquired Lavoisier. He described the oxygenation of blood in the lungs and developed the biological chemistry of the pulmonary circulation described by Servetus. But Lavoisier was an aristocrat and the revolutionary rabble was in the saddle. He was snatched abruptly from his experiments and tried before the revolutionary tribunal. Robespierre drew his finger around his neck and declared, "The republic hath no need of savants". On May 2, 1794, third in a line of 28, Lavoisier rode the tumbril to the Place de la Concorde. The guillotine fell. Lagrange very trenchantly commented, "It took but a minute

to sever that head, France will be a century in producing another like it". This statement was prophetic, for France did not produce another member of the fifth estate like Lavoisier until the advent of Louis Pasteur. With the simplicity to wonder he has been called the father of modern chemistry.

The charming widow of Lavoisier escaped the guillotine. She married Count Rumford who settled in London and founded the Royal Institution. It was here that Sir Humphrey Davy worked. It was here that Michael Faraday, the bookbinder's boy came to hear Davy's lectures. In this institution Faraday made benzene which has molded man's destiny on this planet. Here Faraday broke the lines of magnetic force around a magnet and induced an electric current. On this occasion Gladstone inquired of Faraday, "Suppose you have induced a current into that wire, what of it, Mr. Faraday?" Faraday replied, "Some day you will be able to tax it". Toward the end of a career replete with discovery, someone inquired of Sir Humphrey Davy, "What was your greatest discovery?" Unhesitatingly he replied, "My laboratory boy, Michael Faraday". That attitude of mind—the simplicity to wonder again and again carved the destiny of mankind.

Toward the end of the 18th century one of the most distinguished societies of England was the Lunar Society. Among its members were Erasmus Darwin, grandfather of the immortal Charles Darwin; James Watt, who discovered the power of steam; Joseph Priestley, who discovered oxygen and nitrous oxide; and William Withering, the "flower of English physicians". The principal of Brazen Nose College was seriously ill with dropsy. The standard treatments of the day had failed. The herb concoction of Mrs. Hutton of Shropshire was tried and produced dramatic results. This information reached Withering, who had the simplicity to wonder about it. He sought out Mrs. Hutton and for a few golden sovereigns secured the formula for the herb concoction of many ingredients. Carefully and experimentally on turkeys he tried the activity of the various drugs, ultimately arriving at the conclusion that it was the leaf of the purple foxglove that was responsible for the beneficial results. Those who are physicians in this audience can hear him as he said, "With this drug we can regulate the pulse at will". Little did he realize the importance of that timeless paper published in 1785. "The Foxglove and an Account of Its Medicinal Properties". Withering, the busy clinician; Withering, the distinguished botanist; Withering, the connoisseur in mineralogy; would have been lost to posterity and the same tomb which covers his body would have covered his fame also, if he had not had the simplicity to wonder about and the ability to question an old herb concoction.

The report of the discharge of a gun was not an occasion for alarm at Mackinac—hunting bears (and often Indians) was a recognized occupation. But on June 6, 1822, inadvertently a shot was fired, the report of which reverberated around the world and its echo was to be heard through more than a century of oncoming time. Alexis St. Martin, a youth of nineteen years, was shot while standing adjacent to the barrel of a shotgun. The whole discharge, wadding and all, entered his body in the upper abdominal region. He fell, his shirt was burning—the diagnosis of the bystanders was death. But destiny had carved a different course for St. Martin. Beaumont was called—in 20 minutes he was at the side of the moribund youth. His surgery was effective—his tonic of muriatic acid and wine was alleged to contribute strength, and St. Martin recovered, and after cicatrization of his wound was left with a gastric fistula — a human guinea pig.

It was this unique test subject that enabled Beaumont to study the fundamentals of the peptic digestion process. Beaumont, away from any laboratory of physiology, an army surgeon on the frontier of civilization, adequately described the very basis of the process of protein digestion in the stomach. St. Martin's digestive juice produced at Mackinac visited Franklin Bache, grandson of Benjamin Franklin, at Philadelphia, it crossed the Atlantic and reached the great Swedish chemist, Berzelius at Stockholm, and Professor Dunglison of the University of Virginia determined in it the presence of hydrochloric acid. William Beaumont with an insatiable desire to learn used this unique test subject, Alexis St. Martin (the man with a hole in his stomach) to elucidate for all time the phenomenon of gastric digestion. It is of special historical interest that Beaumont in later life lived for more than a year in the same house with Robert E. Lee in St. Louis, when Lee, a young officer in the engineer corps, was sent to repair the harbor of the city.

The year 1929 was a great one for the human race. It was at that time that Alexander Fleming discovered that the presence of the mould *penicillium notatum* on an agar plate of staphylococcus aureus prevented the growth of the organism. It occurred to him that the metabolic processes of moulds might produce

a substance inimical to the growth of bacteria. He made extracts of the mould-growth material and injected them into mice infected with pneumococcus and streptococcus organisms and was able to save their lives. Actually this experiment of Alexander Fleming reminds one of those words of Louis Pasteur, who said, "In the field of observation, chance only favors that mind which is prepared". Fleming turned to the medical profession and said, "Gentlemen, I have a drug made from a mould that will be useful to the cure of infectious disease". They turned a deaf ear to him. A decade passed.

It was a foggy, cloudy, damp day in February, 1940, that a British bobby who had cut himself while shaving went to Radcliffe Hospital in Oxford with a staphylococcus aureus septicemia. The whole gamut of sulfonamide drugs were tried but he got progressively worse. In the room adjoining, Chain and Florey were repeating the experiment of Alexander Fleming. They injected their penicillin extract into the British bobby and his fever dropped precipitously. He appeared to be getting well but they were out of the drug and the British bobby died. These astute workers saved the urine from the now dead British police officer and extracted from it penicillin, with which they saved the life of a boy a few days later who had a septicemia resulting from an infected hip. The cure was dramatic. The evidence was overwhelming that these British workers had obtained a drug useful in the treatment of infectious diseases.

Soon penicillin was made by the pharmaceutical manufacturers of this country and placed in the hands of our armed forces and then to the civilian population. After five years we look back and see that for the first time on this planet man has an anti-infective drug useful against many deadly organisms that is without any marked toxicity to the human being.

Enough has been said to show that this same science which has brought so many benefits to the human race has at the same time given us the terror of a new fear, that of atomic annihilation. Go with me if you will to the University of California. We are approaching one of its massive buildings. As we enter that door a caption above it catches our eye, "Give me men to match these mountains". What this old world of ours so desperately needs is men and women with the eternal goodness of the Golden Rule in their hearts to match the scientific greatness of this—our hour.

TOASTMASTER ULMER: This, ladies and gentlemen, concludes our program at this point. We are now going to have dancing to the music of Bert Estlow's orchestra. The floor is already prepared, so relax and get ready for the dance.

Thank you very much.

TRANSACTIONS OF THE WOMAN'S AUXILIARY

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TRANSACTIONS OF THE WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

TWENTY-FIRST ANNUAL MEETING

The 21st Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held at Haddon Hall, Atlantic City, April 28, 1948. The meeting was called to order at 9:45 a. m. by the president, Mrs. Lodovico Mancusi-Ungaro. The invocation was delivered by the Reverend Harvey Bennett, First Presbyterian Church, Atlantic City.

The pledge of loyalty to the Woman's Auxiliary was recited.

Mrs. David B. Allman presented the Convention Program and moved its adoption as printed. This was done.

Mrs. Francesco Figurelli, Credentials Chairman, presented her initial report showing 249 registered.

Address of Welcome: Mrs. Edward H. Dyer, president of the Woman's Auxiliary to the Atlantic County Medical Society.

Response: Mrs. Robert B. Walker, President-elect.

The President introduced Mrs. Paul M. Craig, President-Elect of the Woman's Auxiliary to the Medical Society of the State of Pennsylvania.

The Corresponding Secretary, Mrs. Philip J. Santora, read a telegram from Mrs. George McElfatrick, President of the Woman's Auxiliary to The Delaware State Medical Society. Mrs. McElfatrick sent her regrets and kind regards.

Mrs. William E. Dodd, parliamentarian, read the *Rules of Procedure* for the convention and moved their adoption. This was carried.

The President appointed Mrs. Santora to act as timekeeper.

Mrs. G. E. McDonnel moved that the minutes of the 20th Annual Meeting be approved as printed in the last TRANSACTIONS. This was carried.

The treasurer, Mrs. G. E. McDonnel, submitted her annual report. Mrs. Thomas P. McConaghy, Chairman of the Auditing Committee, reported that the treasurer's books had been audited and found to balance. Mrs. Wandall moved that the report of the treasurer together with the attestation of the Auditing Committee be accepted. This was carried.

A Memorial Service was conducted by Mrs. George A. Rogers, Past-President, for the following deceased members:

Burlington County	Mrs. Florence Markley
Camden County	Mrs. A. Haines Lippincott
	Mrs. Levi P. Hirst
Essex County	Mrs. Theodore Teimer
	Mrs. Wm. D. Minningham
	Mrs. James R. Irwin
Hudson County	Mrs. Arthur Walscheid
Mercer County	Mrs. Charles F. Adams
	Mrs. Frank A. Nonziato
	Mrs. Charles H. Waters
Ocean County	Mrs. Irl F. Wentz
Passaic County	Mrs. Thomas O'Grady
Warren County	Mrs. Pearl Stone

REPORT OF THE PRESIDENT

Mrs. C. Chester Chianese, first vice-president, was requested to take the chair during the presentation of the president's report. Mrs. T. P. McConaghy moved that we accept the very fine report of our President with sincere thanks and that this report be published in the TRANSACTIONS. This was carried. (Report appears on page 55.)

REPORTS OF OFFICERS

Reports were submitted by the following officers:

President-elect	Mrs. Robert B. Walker
First vice-president	Mrs. C. Chester Chianese
Second vice-president	Mrs. Thomas P. McConaghy
Recording secretary	Mrs. Banks S. Baker
Corresponding secretary	Mrs. Philip J. Santora
Directors	Mrs. Joseph E. Mott
	Mrs. Chester I. Ulmer
	Mrs. S. H. Jessurun
	Mrs. Norman Nathanson
Advisory Board	Mrs. J. Howard Hornberger, chm.

A motion to accept the reports of officers was carried.

REPORTS OF COMMITTEE CHAIRMEN

Reports were submitted by the following Chairmen:

Conference	Mrs. Robert B. Walker
Finance	Mrs. R. J. McDonald

Historian.....Mrs. Charles F. Merrill
Hygeia.....Mrs. Norman Nathanson
Legislation.....Mrs. O. R. Carlander
Medical history.....Mrs. S. H. Jessurun
Organization.....Mrs. C. C. Chianese and Mrs. Thomas P. McConaghy
Parliamentarian.....Mrs. William E. Dodd
Press and publicity..Mrs. Thomas H. McGlade
Clippings.....Mrs. Sidney Chayes
Public relations.....Mrs. Asher Yaguda and Mrs. Daniel C. Reyner
Postwar plan.....Mrs. Joseph E. Mott
Printing.....Mrs. Anthony V. Ziccardi (read by Mrs. E. Vernon Davis)
Widows and orphans....Mrs. Ernest F. Purcell

A motion to accept the reports of committee chairmen as a whole was carried.

REPORTS OF COUNTY PRESIDENTS

Reports were submitted by the following county presidents:

Atlantic.....Mrs. Edward H. Dyer
Burlington.....Mrs. E. Vernon Davis
Camden.....Mrs. A. G. Pratt
Cape May.....Mrs. Esther Dandois
Essex.....Mrs. Daniel E. Kavanaugh
Gloucester.....Mrs. Chester I. Ulmer
Hudson.....Mrs. William J. Gleeson
Mercer ..... Mrs. Ernest F. Purcell
Middlesex.....Mrs. Nathan Karshmer
Monmouth.....Mrs. Norman Nathanson
Ocean.....Mrs. Raymond Taylor (read by Mrs. Dodd)
Passaic.....Mrs. Albert G. Markel
Union.....Mrs. William O. Wuester, Jr.
Warren.....Mrs. Walter Boquist
Bergen....Mrs. Johnson of Bergen County expressed the thanks of the members to the state officers for attending the re-organization meeting on March 10.
Salem.....The president, Mrs. Frank L. Perry, was introduced. Salem was re-organized on April 12.
Somerset..The president, Mrs. Lewis C. Fritts, was introduced. Somerset was re-organized on April 23.
Hunterdon....Hunterdon was re-organized on April 8.

A motion to accept the reports of county presidents as a whole was carried.

NOMINATING COMMITTEE

The following members were named to serve on the Nominating Committee in addition to Mrs. Lodovico Mancusi-Ungaro as chairman:

Mrs. Oswald R. Carlander
Mrs. G. Ruffin Stamps
Mrs. J. E. Imbleau
Mrs. William Bray

Mrs. Dyer moved that the above members be elected to serve on the Nominating Committee. This was carried and the president declared them elected.

REVISIONS

Mrs. Andrew C. Ruoff, Chairman on Revisions, presented the proposed revisions to Chapter I, Section 1-f: Delete "but they shall not take office until after the convention of the Woman's Auxiliary to The American Medical Association" and moved its adoption. Seconded by Mrs. McDonnel, this was carried.

Mrs. Ruoff then presented the proposed Revisions of the By-Laws to be presented at the Annual Meeting in Chicago.

Article VI, Section 6. General Officers (Constitution). Mrs. McDonnel moved that our delegates be instructed to vote in the affirmative. Seconded by Mrs. Nathanson, this was carried.

Chapter II, Section 2. Election of General Officers (By-Laws). Mrs. Ruoff moved that our delegates be instructed to vote in the affirmative. Seconded by Miss Dandois, this was carried.

Chapter III, Section 3. Duties of General Officers. Mrs. Ruoff moved that our delegates be instructed to vote in the affirmative. Seconded by Mrs. Hornberger, this was carried.

Chapter IV, Section 1, Item 5 and Section 8. Changing Editorial Committee to Publications Committee. Mrs. Ruoff moved that our delegates be instructed to vote in the affirmative. Seconded by Mrs. Jessurun, this was carried.

Chapter V. Official Publication. Mrs. Ruoff moved that our delegates be instructed to vote in the affirmative. Seconded by Mrs. Dodd, this was carried.

Chapter VII, Section 4. Constituent. The Revisions would change the sentence to read: "—dues amounting to one dollar for each of its members for the current year, which shall include subscription to the periodical published by this Auxiliary". Mrs. Ruoff moved that our delegates be instructed to vote in the affirmative. Seconded by Mrs. Dyer, this was carried by a vote of 27 in favor and 26 opposed.

Chapter X—Policy. Mrs. Ruoff moved that our delegates be instructed to vote in the affirmative. Seconded by Mrs. Allman, this was carried.

LUNCHEON

The meeting recessed for luncheon honoring Mrs. Lodovico Mancusi-Ungaro, President. Guests included Dr. Royal A. Schaaf, Dr.

William E. Dodd, and the speaker, Dr. William W. Bolton, Bureau of Health Education, American Medical Association.

The meeting reconvened at 4 o'clock.

REVISIONS

Mrs. Wandall moved that the proposed revision to Chapter VII, Section 4, be opened for re-consideration. Seconded by Mrs. Dyer, this was carried. The vote, taken by answering roll call, was: in favor, 44; opposed, 23.

RESOLUTIONS

Mrs. Dyer read the following resolution and moved its adoption:

Whereas the Woman's Auxiliary to The Medical Society of New Jersey in Convention assembled for its 21st Annual Meeting, April 28, 1948, in Atlantic City, has been the recipient of many courtesies and unusual honors, therefore, be it resolved:

That a letter of deep appreciation be written to the Board of Trustees thanking them for their many courtesies and votes of confidence as well as the supplementary budget of $1000 for use of the public relations committee.

That letters of thanks for their fine support and opportunities of service to them in their official capacity be sent to Dr. Royal A. Schaaf, President of The Medical Society of New Jersey, Dr. William E. Dodd, Chairman of the Advisory Committee for The Medical Society of New Jersey, Dr. Butler, Chairman of the Welfare Committee, Dr. Samuel Sica, Chairman of the Public Relation Committee, Dr. Samuel Blaugrund, Chairman of the Public Health Committee, Dr. Frederic J. Quigley, Chairman of the Legislative Committee, Dr. Norman M. Scott, Director of the Medical-Surgical Plan, Dr. Henry A. Davidson, Editor of The Journal, Mrs. Edith Madden, Executive Assistant, Mrs. Miriam Armstrong, Assistant Editor, Mr. James E. Bryan, Executive Officer, and Dr. Asher Yaguda, Chairman of Exhibits.

That a letter of thanks be written to Mrs. David B. Allman, Convention Chairman, thanking her and her fine committee for their many courtesies and the loving care with which they made our convention the outstanding success that it was.

That a letter of appreciation be written to the manager of the Chalfonte-Haddon Hall thanking him and all those who may have contributed for their many courtesies which have added so much to our comfort and pleasure.

That letters of appreciation be written to the presidents of the county medical societies who have given the State Auxiliary permission to organize, thanking them and their medical societies for their many courtesies to us.

That a letter of appreciation be written to the Bureau of Health Information thanking them for their courtesy in sending Dr. Dean F. Smiley to speak at the June Conference, and Dr. William W. Bolton to speak at our annual luncheon.

That a letter of thanks be written to Dr. William W. Bolton for his contribution to our annual luncheon.

That a letter of thanks be written to Dr. Lillian Calsica and the students of the art class of Newark State Teachers College who made the booth.

That this resolution be spread upon the minutes and that the Corresponding Secretary be instructed to send the necessary letter to each person mentioned therein.

Seconded by Mrs. Subin, this resolution was carried by acclamation.

FINAL CREDENTIALS REPORT

The Credentials Chairman, Mrs. Figurelli, submitted the final credentials report showing a total of 299 members and 33 guests registered, and moved the acceptance of this report. Seconded by Mrs. Yaguda, this was carried.

Mrs. Figurelli also submitted her Annual Report which was accepted.

ELECTION OF OFFICERS

Mrs. Frederick G. Wandall, Chairman of the Nominating Committee, submitted the following candidates for election:

President-elect	Mrs. Norman Nathanson
First vice-president	Mrs. Daniel C. Reyner
Second vice-president	Mrs. Joseph E. Mott
Recording secretary	Mrs. Banks S. Baker
Treasurer	Mrs. Gerald E. McDonnel
Directors	Mrs. Frank S. Forte
	Mrs. W. L. Rumsey

Mrs. McConaghy moved that the Secretary be instructed to cast the unanimous ballot of the Auxiliary for these candidates. The motion was unanimously passed. The Secretary cast the ballot and the President declared these candidates duly elected.

INSTALLATION OF OFFICERS

Mrs. Lodovico Mancusi-Ungaro presented the gavel to Mrs. Robert B. Walker who accepted. Mrs. Mancusi-Ungaro then installed the remaining officers.

There being no further business, the President declared the 21st Annual Meeting adjourned.

Respectfully submitted,

Mrs. Banks S. Baker,
Recording Secretary.

Reading Committee:
Mrs. A. J. Casselman
Mrs. A. G. Pratt

ANNUAL REPORT

Mrs. Lodovico Mancusi-Ungaro, President

Before I start on the actual details of the work of this regime, I thank each and every Auxiliary member for this opportunity of serving as your state President. It has been a delightful experience, as well as an honor, an honor which I have sought to discharge to the best of my ability, dedicating myself to this work not only for my husband and my children, but in memory of my father.

As your president, I have met four times with Dr. William E. Dodd, adviser for The Medical Society to the Auxiliary, and his committee; and I have had innumerable conferences with Dr. Schaaf. I wish to thank these men publicly for their many courtesies to me and for the loyalty they have shown in the work of the Auxiliary. The Auxiliary has a real friend in these physicians, and if our efforts have the approval of The Medical Society, it is largely due to their staunch support and confidence in our ability. Mrs. Armstrong, Mrs. Madden, Dr. Blaugrund, Dr. Quigley, Dr. Davidson, Dr. Scott, Dr. Tidwell, and Mr. Bryan have all been helpful to me and to the Auxiliary, and deserve special mention and thanks. It is fitting too, at this time to pay tribute to my Auxiliary Advisory Board whose loyal affection backed my every move.

In May, I had the honor to address the Welfare Committee of The Medical Society of New Jersey. I told them women were taking an interest in legislation all over the state, and that our usefulness to them in moulding the thinking of these groups of women was largely dependent on the way they furthered our efforts; that there were eight unorganized counties where policy forming movements among women's groups in no way felt the guidance of The Medical Society; that it was imperative that the county medical societies follow the example of the State Society which had been set for the first time that day, and include key Auxiliary committee chairmen on the committees of the county medical societies to train the Auxiliary leaders of tomorrow. I submitted a ten-point program, which is included in the report of the historian. To the Auxiliary to The Medical Society here assembled in Convention, I am proud to report that through the wholehearted cooperation of my many chairmen and your county presidents who have served you so loyally this year, progress has been made in all phases of this program.

As your representative I attended the Annual Convention of the Woman's Auxiliary to the State of New York in Buffalo, last May, the Annual Convention of the Woman's Auxiliary to the State of Pennsylvania, in Pittsburgh, last September; the Chicago Conference of the National Auxiliary, in November 1947; Health Day of the Woman's Auxiliary to the Philadelphia County Medical Society, April 6, 1947; the formation of the inner group council to study legislation unfavorable to women instituted by the Trenton College Club; the Home Safety Forum of the Woman's Division of the New Jersey State Safety Council; the New Jersey Milk Control Board luncheon; went as an observer to the National Public Health Conference at Princeton; and sent a representative to the dinner called to form a State Committee for the Recruitment of Nurses. At a National level, I have served Mrs. Hamer as Chairman of Courtesy Resolutions, and Mrs. Kice as Chairman of Conference Resolutions.

I have had daily conferences with Mrs. Yaguda who has done this magnificent work for us in public relations; first on the June Conference; and then on her plans for the county councils for the improvement of the school health services. If this work receives national recognition, it is due entirely to Mrs. Yaguda's devotion to the development of this project. In connection with this project, I attended the dinner given in Trenton for the Commissioner of Education; and the Conference given by the State Consulting Committee; have attended the formation of three county councils, and have spoken at four of these meetings, and have had the honor of addressing one county medical society on this subject.

I have assisted the scholarly Mrs. Carlander at every turn, and with her have the distinction of being the first two members of our Auxiliary to speak in the Senate Chamber on a matter of public welfare. By radio, I spoke for 45 minutes on two programs which highlighted in advance our June 16th program; Mrs. Yaguda and I broadcast for 30 minutes on a safety program; and Dr. Dodd and I for 30 minutes on a history of our Auxiliary.

I have met with Mrs. Walker, your President-Elect, several times to assist her in planning her Conference, suggesting only manner and method of procedure. I have seen to it that Mrs. Walker was consulted when it came time to draw up a budget for the incoming

regime, in hopes that such a budget would prove adequate for her incoming program.

As your President, I have conducted all regular meetings of the Executive Board; have visited every county in the state except two; have given a speech of instruction of Auxiliary policies to eleven counties; speeches for reorganization to six counties, five of which were successful; have spoken against socialized medicine at six county public relation days, reaching approximately 1500 key lay women who had been invited as representatives of their organizations; have spoken at one regional conference of public relations chairmen; have attended every meeting of the Welfare Committee of The Medical Society of New Jersey. I have called on those who were sick or in sorrow, and have tried to the best of my ability to fuse this Executive Committee into a unit which could better serve The Medical Society of New Jersey. I have traveled to ninety-four places in this state as your official representative; a distance of 10,123 miles, and have written over 1100 letters.

My most momentous decision was when I risked the success or failure of my whole regime on the June Health Education program, which was developed so magnificently by Mrs. Yaguda. I wanted leadership in health education among the women's groups of the state for our Auxiliary, and with that in mind I cast the die. It is my hope that this program will serve as a pattern of endeavor, and that once and for all we have justified our existence as other than a social group.

My entire board has been most cooperative; none of these accomplishments would have been possible without their loyal assistance and cooperation. I shall treasure for life the friendships I have made in serving you, and the many pleasant times I have had throughout the state.

ANNUAL HISTORY 1947 - 1948

The activity of the Woman's Auxiliary to The Medical Society of New Jersey took on an aspect of seriousness from the very start when Mr. Arthur C. Conrad, associate administrator of the National Physicians Committee, gave an inspiring address at the post-session Board meeting. This meeting followed the breakfast tendered past-presidents, the outgoing and in-coming executive boards, Dr. William E. Dodd, our adviser from The Medical Society, and Dr. Royal A. Schaaf, President of The Medical Society of New Jersey by our newly elected state president, Mrs. Lodivico Mancusi-Ungaro. Before we go further into the work of this regime it is fitting that we pause to speak of what the Auxiliary owes these two men: Dr. Dodd and Dr. Schaaf. They have been real friends of the Auxiliary and many of the accomplishments of the Auxiliary are due to their staunch support and confidence in our ability.

A historian is impressed by the scope and vision of the entire Health Education Forum. Fifteen hundred invitations were sent to representatives of women's groups, to educators, hospital administrators, clergy, state and municipal officials, to social, public health and welfare groups. The President of the Woman's Auxiliary to The American Medical Association attended. One and one-half hours of advance radio publicity was obtained, and advance notices in 21 newspapers; follow-up publicity in 15 newspapers, the New York *Times*, the *Herald Tribune*, and the Philadelphia *Inquirer*. The July issue of *Public Health News* devoted three and one-half pages to reporting this meeting. The informal discussions at the four tables were: *Common Traffic Accidents of Children;* chairman, Colonel Charles H. Schoeffel, Superintendent of New Jersey State Police; *Health of Women in Industry*, chairman, the Honorable Harry C. Harper, Commissioner of Labor, State of New Jersey; *Student Nurse Enrollment*, chairman, Miss Margaret T. Corwin, Dean of Women, New Jersey College for Women; and *Alcoholism*, chairman, a member of Alcoholics Anonymous. Luncheon was served to the guests, a resume of each panel of the morning given by the chairman, and a culminating talk on *Health Education* given by Dr. Dean F. Smiley, Consultant in Health and Physical Fitness, American Medical Association. This talk was later reprinted as an editorial in the leading newspaper of the state.

One week later at the Workshop, the Auxiliary was asked by Dr. Wilson G. Guthrie, Director of Health, Safety and Physical Fitness of the Department of Education of the State, to implement the four point program which had been developed jointly by the Department of Education and The Medical Society of New Jersey. Permission having been granted by The Medical Society, the Governor was informed of our plans, and our approach commended by him. The work of

forming these councils has been carried on at a county level by the county public relations committees under the dynamic leadership from a state level of Mrs. Asher Yaguda and her vice-chairman, Mrs. Daniel C. Reyner. To date 13 councils have been formed; dates set for the organization of 3; progress being made in 3 counties; with 2 counties not participating at this moment, an incredible accomplishment for six months! The program has received notice in the *Journal* of the American Medical Association (135:78) in the April, 1948 issue of *Medical Economics;* and in the March, 1948 *Bulletin of the National Auxiliary.*

This council has earned its place on the agenda of The Medical Society's program at the Annual Meeting with our public relations chairman making a progress report. For the first time too, the Auxiliary will have its own booth among the Educational Exhibits of The Medical Society. This booth will highlight the school health work of the Auxiliary with clever, colorful paper sculpturing.

In addition to the public relations phase of this first Workshop which completely stole the show, the Workshop itself was a new variation of the three Regional Conferences which had been held in previous years. Each subject matter chairman met with the county chairman who was her counterpart, and the physician who headed that work in the state, and the work for the coming year discussed and plans laid to coordinate and standardize the county Auxiliary programs. This entire project was carried out under the guidance of our gracious president-elect, Mrs. Robert B. Walker.

Our President had the honor of presenting her program in person to the Welfare Committee of The Medical Society. She asked for their cooperation in increasing the membership of the Auxiliary, in increasing the value of our organization to them. She presented the following ten-point program of work:

1. Promote friendliness among the wives of physicians.
2. Increase Auxiliary membership.
3. Organize the unorganized counties.
4. Assist The Medical Society at all times when requested.
5. Promote *Hygeia.*
6. Actively support all health movements endorsed by The Medical Society.
7. Promote favorable publicity for physicians through all media of communications.
8. Coordinate and integrate the functioning of the component Auxiliary committees with the corresponding committees of The Medical Society by means of a "Workshop" once a year.
9. See that our members know the stand of all legislators on health questions, and that analyses of pending legislation are distributed effectively.
10. Assume leadership among women's groups of New Jersey in health education.

For the first time, key Auxiliary women have attended all of the meetings of the Welfare Committee of The Medical Society with key chairmen of the Auxiliary meeting with key committees of The Medical Society. Such has been the progress of this administration that our president-elect was asked to present her plans in person to the Trustees, and has the distinction of being the first president-elect so honored.

In the field of legislation under the scholarly leadership of Mrs. Carlander the membership has been informed and alerted on medical and health legislation at a state and county level, the legislative highlight for the Auxiliary was when the Woman's Auxiliary was asked with full approval of The Medical Society to appear before the Senate Committee for Public Health to speak in favor of a bill permitting the establishment of county and part county health units. We are proud of the presentation Mrs. Mancusi-Ungaro and Mrs. Carlander made in the Senate Chamber; and proud too, that our Auxiliary for the first time in its history has been given an opportunity to speak on a question of public welfare.

Mrs. Nathanson has reported 230 subcriptions to *Hygeia;* a gain over last year. All secondary schools in the counties that were organized at the beginning of this regime are receiving *Hygeia,* either as a gift subscription or voluntary subscription. Mrs. Jessurun has been busy collecting data on Medical Men of World War II, as well as biographic sketches of men outstanding in the medical profession in New Jersey. She brings to this the loving care that makes this work live. Mrs. McGlade has made a scrapbook of Auxiliary publicity, and has retyped more than one hundred pages for publication. For this thankless task, we owe her a crown of glory. Mrs. Chayes has made a scrapbook of clippings on medical topics. Mrs. Purcell has taken care of the widows and orphans. Mrs. Alexander has resolved and Mrs. Ruoff revised at every meeting. Mrs. McDonald has had nightmares trying to stretch the limited finances to meet the ambitious program set up by our president, and Mrs. Dodd held the reins tightly with Robert's *Rules of Order.* Mrs. Allman and her entire committee prepared a beautiful convention for us, and all past presidents have cooperated with the reorganization plans of Mrs. McConaghy and Mrs. Chianese.

The programs under Mrs. Mason's capable guidance were:

October—Miss Lulu P. Dilworth, Department of Education, who spoke of the coordinating work of the nurse in any school health program. At that time we also heard from our new Executive Officer, Mr. James E. Bryan. In January we heard our National Chairman of Legislation, Mrs. Bruce Schaefer of Atlanta, Georgia, for whom our President entertained her whole Board at the Trenton Country Club. Mr. Edward W. Stegen, Chicago, of the National Physician's Committee for our March meeting, not to mention again Mr. Arthur Conrad of our April Breakfast, nor Dr. Dean F. Smiley of the June Conference all make an imposing array of speakers leading up to the climax—which we are anticipating for our annual luncheon of the Convention—at which time Dr. William W. Bolton will address us on the *Role of the Physician's Wife in Community Health Education.*

In the field of organization Mrs. McConaghy and Mrs. Chianese have labored without end. No stone unturned, no county unapproached, some work in all counties despite the greatest blizzard of our history. Of the eight counties unorganized at the beginning of our regime under the thorough diligent planning of these co-chairmen Bergen, Cape May, Hunterdon, Salem have been organized and have included a subscription to the *Bulletin* in their dues. Somerset has elected a president and a steering committee. Two members at large secured from Morris; four from Sussex; and 33 from Cumberland, despite the declared opposition of their medical society to an Auxiliary. This extensive work removes every dot from the map of National. In addition to these 48 known subscriptions to *Bulletin;* Mrs. Sauerbrun has a record of 133 subscriptions as of March 1.

Of the counties organized at the beginning of this regime all have participated in the public relations activities of the state—either forums, or the formation of the county health councils, or both. As a subchairman of public relations Mrs. Mott, the chairman of postwar planning, has distributed 1500 pieces of literature on nurse recruitment and prepayment medical service plans; Mrs. Matheke, the Chairman of Safety, 1000 pamphlets on Home Safety and letters to all counties offering programs of safety. Our corresponding Secretary, Mrs. Santora, has compiled from lists sent in by County Public Relations Chairmen, a file of 2000 prominent lay people. Nine counties have held open forums on public relations topics. Eight county Auxiliaries have given nurse scholarships in their counties. Despite 14 deaths, the membership of the Auxiliary has increased.

The eight major radio stations of the state have been contacted by the Auxiliary and have carried the series of platters of the American Medical Association, all of them once, some of them twice. In addition, broadcasts on safety, cancer, on school health councils, health education, health of women in industry, and on the history and accomplishments of the Auxiliary have been held, a total of 4210 minutes of radio time. All of the counties organized at the beginning of this regime have placed *Hygeia* in the schools of their county; all have had legislative information at a state and county level.

In addition to the eight nurse scholarships, the major philanthropies have been, books in libraries as memorials for Auxiliary members and medical men; donations to Cancer Drive; $400 to place the child of a physician in college; $100 towards a television set in a Veterans Hospital; donations to send CARE packages to doctors in Holland; $450 to buy a new stove in a county hospital; $1000. medical benevolent fund.

This year has been beset by unusual illness and tragedy: Dr. Scammell, the junior past president of The Medical Society; the husbands of our beloved Mrs. Charles Merrill and Mrs. Gerald E. McDonnel, as well as Mrs. Charles F. Adams, a past president of our State Auxiliary, and Mrs. A. Haines Lippincott, our first Auxiliary President. Her dynamic leadership, her unswerving loyalty to our Auxiliary, her generous contributions of self and time to our interest will long remain in our hearts. To her we owe some of our outstanding speakers of the June Forum. We can truly say "Her work lives after her".

If this can be said of Mrs. Lippincott it can also be said of our president. She has given generously of her time and talent. She has written 1071 personal letters and has traveled 10,123 miles for us this year; hers is the vision that foresaw the leadership inherent in the June 16 program; hers the dedication to this work. "Long may her enthusiasm remain in our hearts."

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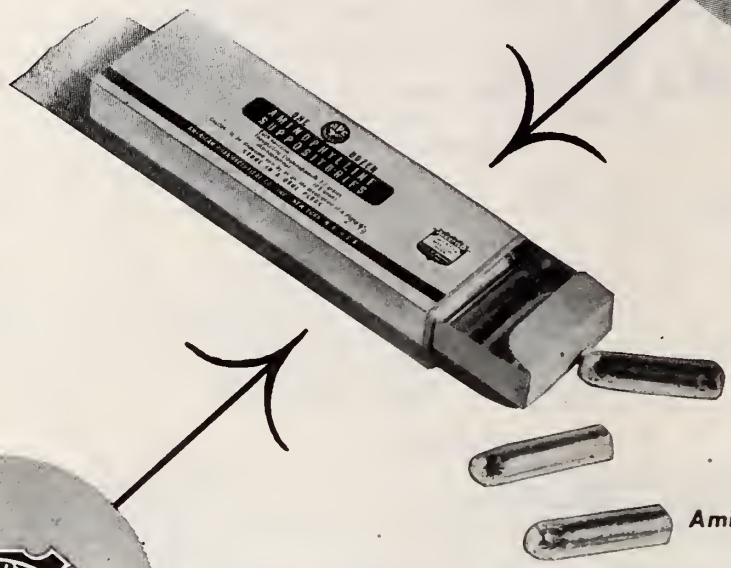
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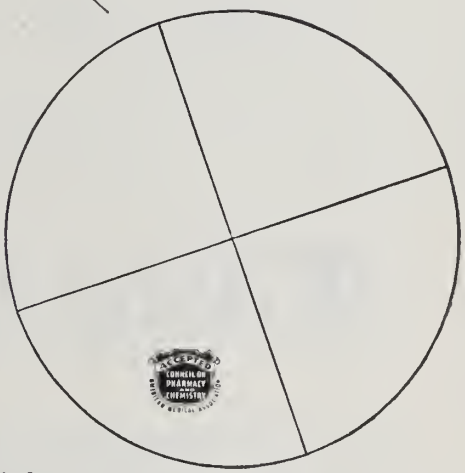
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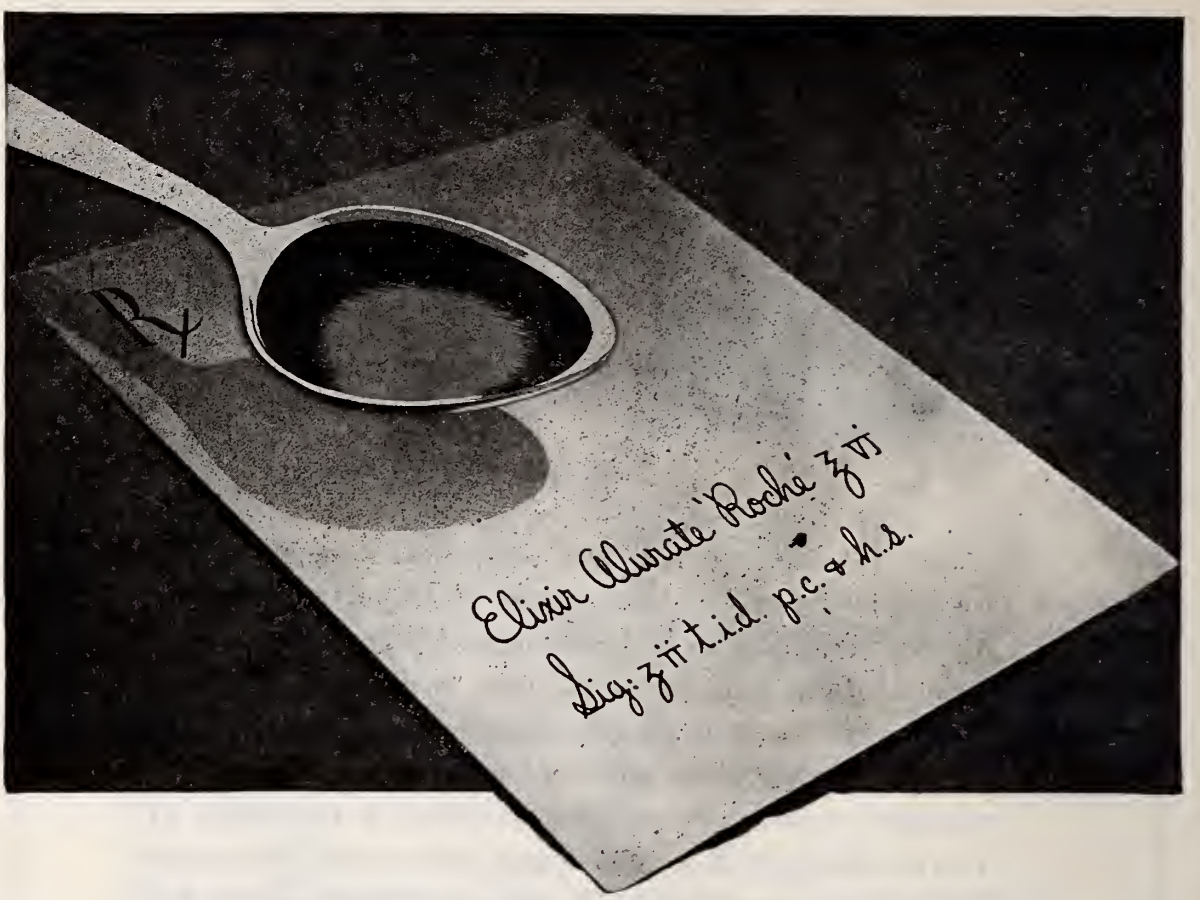


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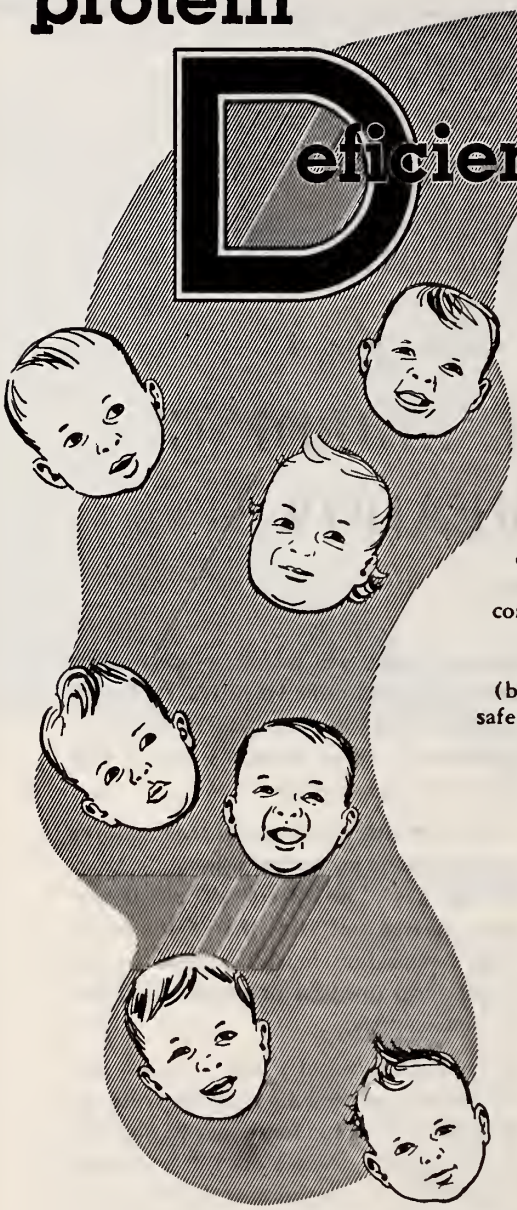
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*A.M.A.: *Handbook of Nutrition, Chicago, 1943.*

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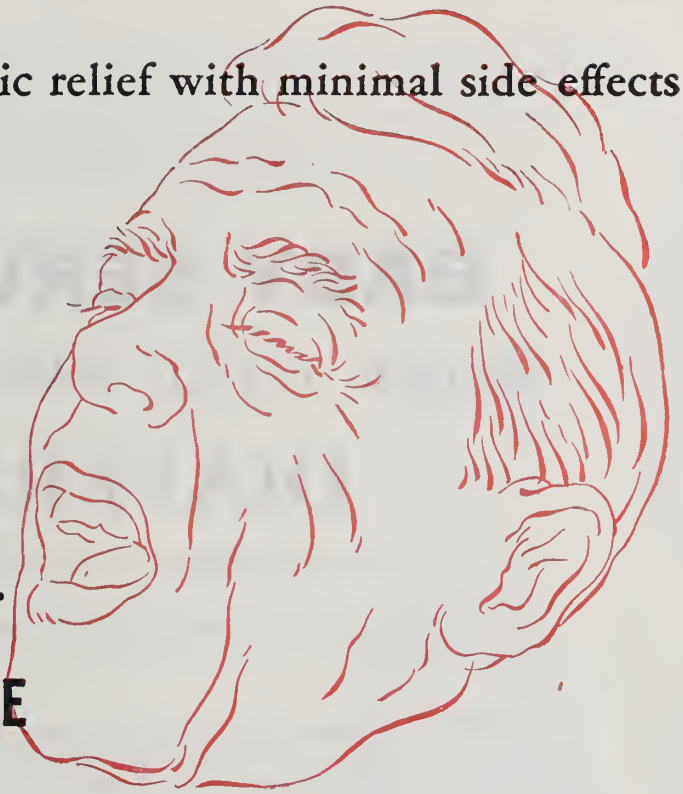


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1. ARBESMAN, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. LOVELESS, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. BERNSTEIN, ROSE and FEINBERG: *Ill. Med. Jl.*, 92: 2, 1947.
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... a Council Accepted Modified Protein Hydrolysate.*

*See Council Report, J.A.M.A. 136:692-693 (March 6) 1948.

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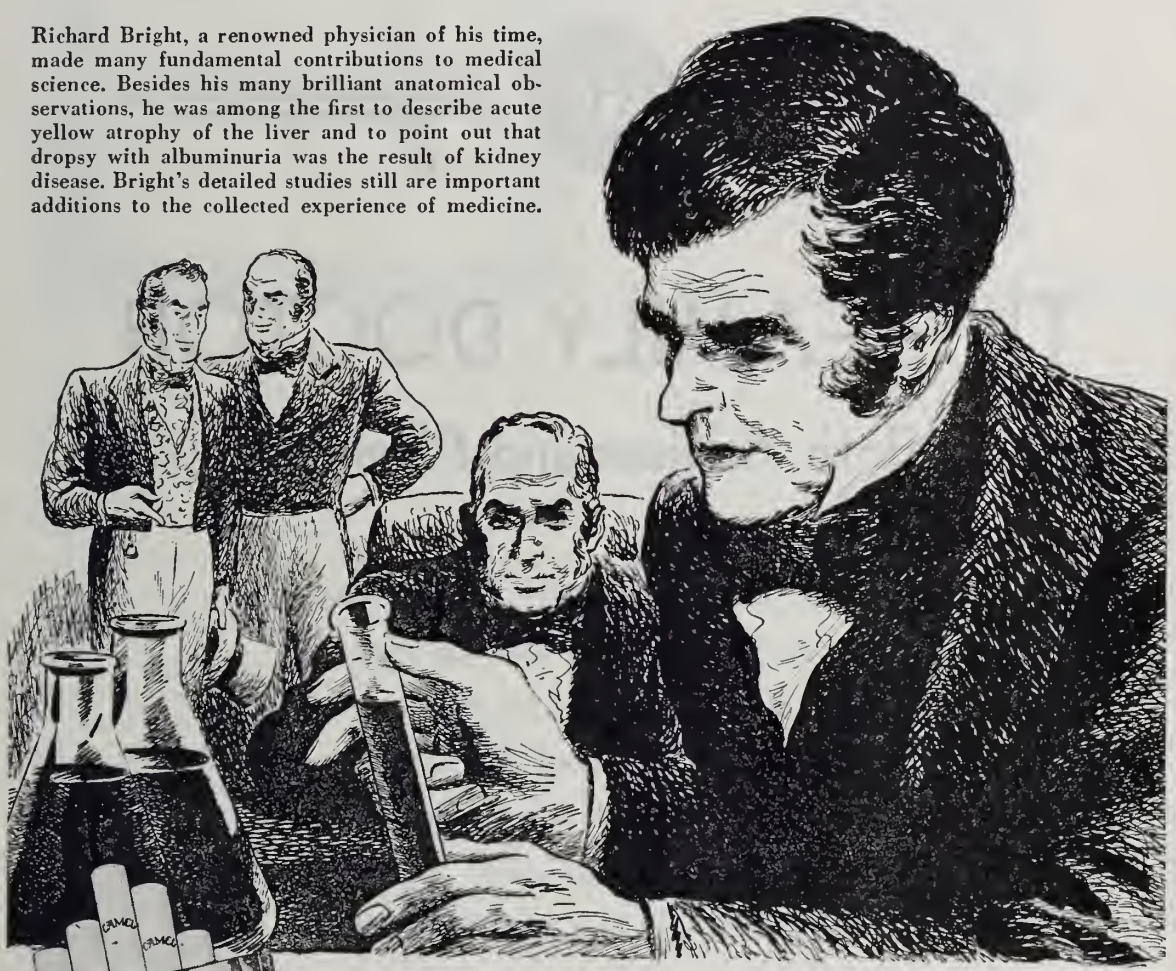
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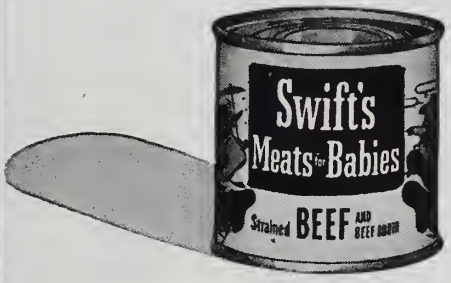
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Your patients not only look to you for medical care but also for advice. That is why it is so important when you believe they need eye care that you refer them to your colleague—The Eye Physician—who in turn will refer them to a Guild Optician.

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EFFECTS OF INFECTIOUS DISEASES AND TRAUMA ON BODY PROTEIN

There are two large groups of disorders which produce generalized protein breakdown: *infections*, acute and chronic, and *trauma*. Infections usually produce fever. A rise in temperature of one degree Fahrenheit means a seven to ten per cent rise in metabolic rate. In addition, bacterial toxins may cause protein breakdown by affecting the cells directly. For these reasons, loss of weight is an outstanding feature of infectious diseases. Diet, especially during convalescence, is therefore high in calories and in the *proportions of protein*. Certain types of injury produce an intense protein *breakdown* which may last for several weeks. The negative nitrogen balance which follows injury is difficult to counteract. *Extremely high protein intakes* are needed to minimize the loss of body tissue.*



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Palatable protein supplementation for patients on soft, smooth diets

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ALSO SWIFT'S DICED MEATS — for high-protein diets requiring foods in a form less fine than strained, these tender, juicy pieces of meat are highly desirable.



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All nutritional statements made in this advertisement are accepted by the American Medical Association Council on Foods and Nutrition.





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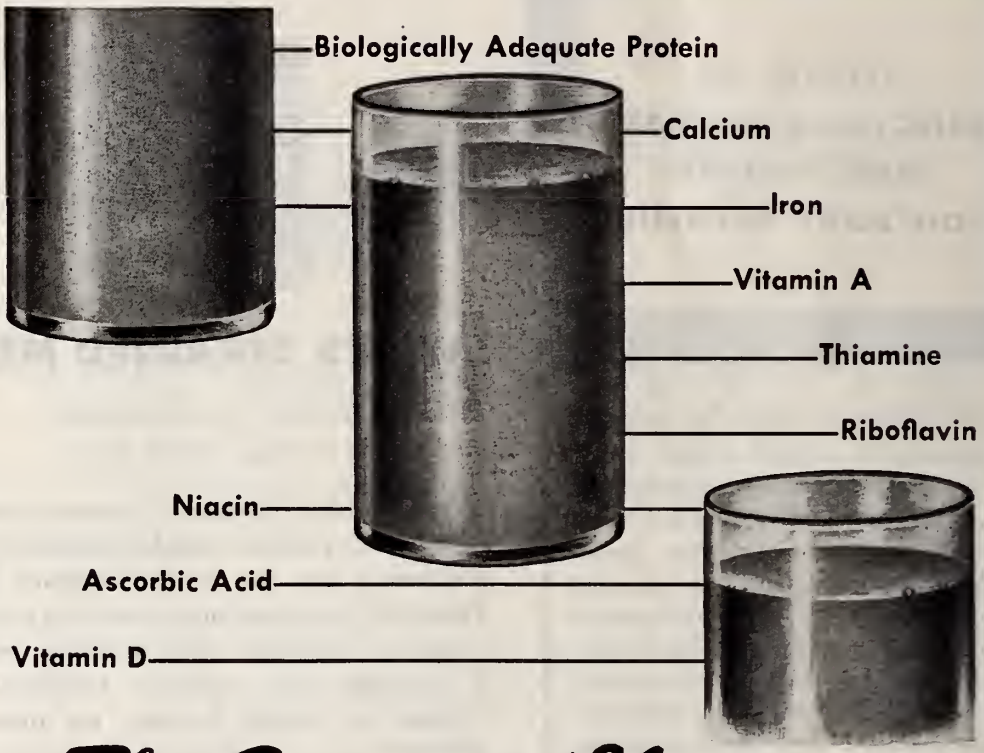
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Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

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PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.



The Petechiometer*
a Rexall exclusive

Rexall

DRUGS

YOU CAN DEPEND ON ANY DRUG PRODUCT THAT BEARS THE NAME REXALL.

The Petechiometer—exclusive with Rexall—is a new device used in the measurement of capillary fragility. It is a simplification of the suction-type resistometer used in the Dalldorf test.

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The air is expelled from the suction cup by pressure of thumb on plunger. The cup is then placed lightly but firmly upon the skin. As thumb pressure is released, spring action applies suction. After one minute, suction is released; after five minutes, petechiae are counted. By moving an adjustable "stop" ring the test may be repeated at two additional suction levels. Remember that increased capillary fragility is a complication of many clinical conditions.

You can obtain the Petechiometer only at drug stores displaying the familiar blue and white Rexall sign—your assurance of drugs manufactured under rigid laboratory control, compounded with superior pharmacal skill. Your Rexall druggist will be glad to tell you more about the Petechiometer. Or write to Rexall Drug Company, Los Angeles, California.

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PHARMACEUTICAL CHEMISTS FOR MORE THAN 45 YEARS

There'll be fewer sleepless nights this season



BY JULIO DE DIEGO

THE INTRODUCTION of Abbott's new antihistaminic, THENYLENE Hydrochloride, means that more allergic persons than ever before will be working, playing, sleeping in greater comfort. Some hay fever patients will be symptom-free; others will experience relief to a lesser degree. Side-effects will be limited.

In a series of 112 patients with seasonal hay fever (including pollinosis caused by trees, grass, weeds and molds) it was reported that 70 percent were benefited following treatment with THENYLENE Hydrochloride. From a number of independent investigators come reports on various allergies treated with THENYLENE: in a total of 695 such cases, 67 percent were benefited. A significant number of patients in one test group who received several different antihistaminics, reported a better tolerance for THENYLENE, with fewer side-effects.

While no harmful effects have been reported, a total daily dose exceeding 400 mg. (0.4 Gm.) is not recommended, nor continuous use of the new drug beyond eight weeks.

If you would like to try this new antihistaminic, just drop a line to Abbott Laboratories asking for your professional sample and descriptive literature. Or ask your pharmacist—he has THENYLENE Hydrochloride in sugar coated tablets of three sizes, 25 mg., 50 mg. and 0.1 Gm. in bottles of 100, 500. ABBOTT LABORATORIES, North Chicago, Ill.

prescribe **Thenylene®** **Hydrochloride**

(Methapyrilene Hydrochloride, Abbott)

Abbott's NEW Antihistaminic

1. Feinberg, S. M., Bernstein, T. B. (1947), Histamine Antagonists, VIII. N-(α-Pyridyl)-N-(α-Thienyl)-N', N'-Dimethylethylenediamine, a New Antihistaminic Compound. Experimental and Clinical Experiences, J. Lob. & Clin. Med., 32:1370, November. 2. Feinberg, S. M. (1947), The Antihistominic Drugs, Amer. J. Med., 3:560, November.

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Wouldn't you like to get rid of dusty vacuum bags forever? Wouldn't you like to pour dust away as easily as dirty dishwater?

You can, with Rexair—the amazing new home appliance that collects dust in water instead of a bag. You just pour the water down the drain and flush—dust and dirt go with it.

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Rexair does dozens of household jobs. Rexair cleans rugs, drapes, and upholstery; scrubs, rinses, and dries floors; dusts furniture; waxes and moth-proofs. Rexair improves even the air you breathe—takes in dust and dirt-laden air and fills the room with clean, washed air.



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CORN SILAGE — 24 lbs.



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ALFALFA SILAGE — 13 lbs.



GRAIN MIXTURE — 13 lbs.
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1. Molasses	1.9 lbs.
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3. Salt	0.2 lbs.
4. Soybean Meal	0.5 lbs.
5. Gluten Feed	0.5 lbs.
6. Linseed Meal	0.1 lb.
7. Distillers Grain	0.5 lb.
8. Brewers Grain	0.5 lb.
9. Bran	1.5 lbs.
10. Oats	2. lbs.
11. Corn	1.5 lbs.
12. Babassu Meal	1. lb.
13. Malt Sprout	1.5 lbs.
14. Barley	1.5 lbs.



WATER — 85 quarts

THIS SCIENTIFIC daily ration was developed after years of study by the Walker-Gordon Laboratories.

It is remarkably rich in vitamins and health-giving minerals . . . And that's one big reason why Walker-Gordon cows produce a milk far superior to the type you get from cows that are fed in the ordinary, unscientific way.

Take Vitamin A, for example. The alfalfa fed a Walker-Gordon cow is not ordinary alfalfa, but a special dehydrated kind containing more Vitamin A. As a result, her milk contains more Vitamin A than many ordinary milks.

And though the quantity of some other vitamins varies in ordinary milk (according to the season and what the cows find to eat), the vitamin content remains uniformly high in Walker-Gordon Certified . . . the year 'round.

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So it's easy to see why more and more physicians recommend Walker-Gordon Certified to their patients. They believe it's well worth a few pennies extra to get this marvelously pure milk with all its added nutritional values.

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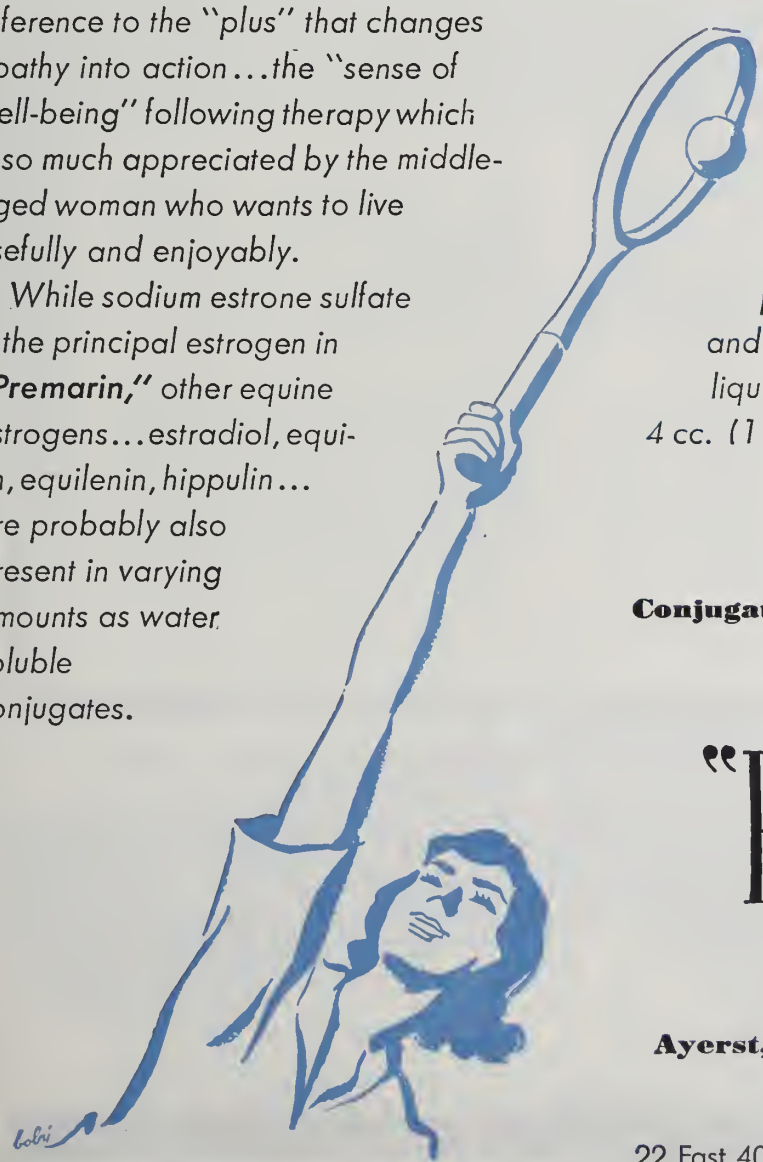
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middle age + verve

Verve or apathy in middle age? For the menopausal patient this is usually determined by the degree of relief from the distressing symptoms so often associated with declining ovarian function.

Gratifying and prompt remission of disturbing symptoms may be obtained with **"Premarin."** *Outstanding among comments made by patients receiving this naturally occurring, orally active estrogen, is the reference to the "plus" that changes apathy into action...the "sense of well-being" following therapy which is so much appreciated by the middle-aged woman who wants to live usefully and enjoyably.*

While sodium estrone sulfate is the principal estrogen in **"Premarin,"** *other equine estrogens...estradiol, equilin, equilenin, hippulin... are probably also present in varying amounts as water soluble conjugates.*



Three potencies of **"Premarin"** *enable the physician to fit the dosage to the individual needs of the patient: 2.5 mg., 1.25 mg. and 0.625 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).*

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Conjugated Estrogens (equine)

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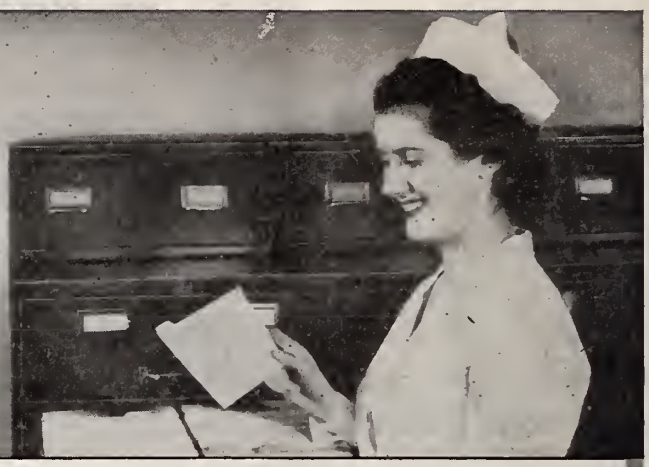
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*Estrogenic Substances (water soluble) also known as Conjugated Estrogens (equine)

Findings from the Saratoga Spa records*



CARBON DIOXIDE BATHS in circulatory diseases

The physiological observations of the influence of carbon dioxide baths show a decrease in the pulse rate, an increase in the pulse pressure dependent mainly on a drop of the diastolic pressure, a better emptying of the venous blood vessels, a hyperemia with increased capillary circulation, a slightly elevated minute volume output of the heart, an increase in respiration and the elimination of large quantities of the carbon dioxide through the lungs.

In evaluating the results of this treatment for patients with circulatory disorders there is no ideal test of cardiac function and in these patients the ability to walk or exercise without the production of symptoms is used in judging their clinical gain. In addition, in the patients with coronary disease suffering from anginal attacks, it is striking to note the decrease in the frequency and severity of these attacks. In some patients they will disappear completely.

Objective changes as seen in physical examination and in the studies of pulse rate, blood pressure, roentgen ray findings, electrocardiographic tracings, and vital capacity are noted in many patients.

The clinical improvement of many patients undergoing treatment, their continued well being after their return home and their desire periodically to return for further treatment all indicate that the carbon dioxide bath has its place in the treatment of disorders of the circulation.

**As printed in International Clinics, Vol. 1, page 199, March 1937*

The SARATOGA SPA

"Physician, Give Heed to Thine Own Health"

Many physicians have come to the Spa for the same kind of treatments that have helped their patients here. After a restorative "cure" at the Spa, you, too, will return to your practice refreshed—revitalized—ready for the busy days that lie ahead.

For professional publications of the Spa, and physician's sample carton of bottled waters with their analyses, write W. S. McClellan, M.D., Medical Director, Saratoga Spa, 159 Saratoga Springs, New York.

Listed by the Committee on American Health Resorts of the American Medical Association

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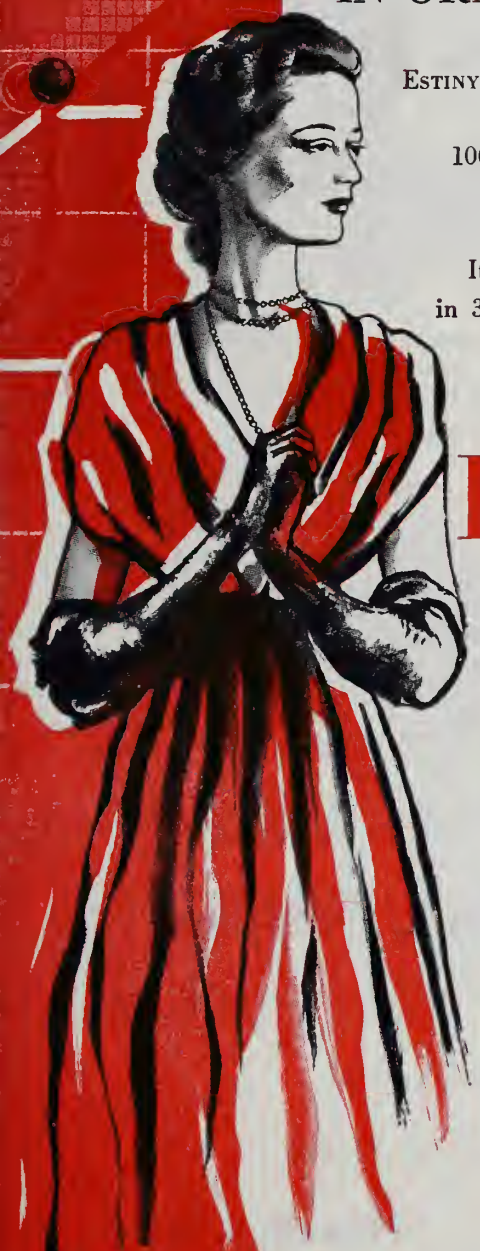
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ESTINYL Tablets, 0.02 (buff) or 0.05 mg. (pink), in bottles of 100, 250 and 1000.

ESTINYL LIQUID, 0.03 mg. per 4 cc. (teaspoonful), in bottles of 4 and 16 oz.

BIBLIOGRAPHY: 1. United States Dispensatory, ed. 24, Philadelphia, J. B. Lippincott Company, 1947, p. 1446. 2. Wiesbader, H., and Filler, W.: Am. J. Obst. & Gynec. **51**:75, 1946. 3. Allen, W. M.: South. M. J. **37**:270, 1944. 4. Lyon, R. A.: Am. J. Obst. & Gynec. **47**:532, 1944. 5. Groper, M. J., and Biskind, G. R.: J. Clin. Endocrinol. **2**:703, 1942. 6. Soule, S. D.: Am. J. Obst. & Gynec. **45**:315, 1943.

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RELATIVELY small doses of Diethylstilbestrol, Lilly, whether given parenterally or orally, can produce the desired result in the control of menopausal symptoms. Excessively large doses of either natural or synthetic estrogenic preparations may cause nausea. A cautious approach in establishing a maintenance dose will prevent untoward reactions. Cyclic administration of Diethylstilbestrol, Lilly, results in an effect which simulates the progression of estrogen levels occurring in normal ovarian cycles.

The dosage forms of Diethylstilbestrol, Lilly, include tablets, ampoules, and vaginal suppositories. They are readily available at your local retail pharmacy.

Lilly

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A 15 x 12 reproduction of this Dale Nichols illustration is available upon request.

Lilly in Switzerland

OF ALL of the admirable qualities of the Swiss people, unselfish, humanitarian service is characteristic. It was a Swiss, Jean Henri Dunant, who founded the Red Cross. The executive committee, known as the International Red Cross Committee, is made up entirely of Swiss citizens. Similar organizations doing private relief work for unfortunates all over the world have their headquarters in Switzerland and are stanchly supported by the Swiss people.

Although Lilly products had been sold in Switzerland for many years, it was not until 1947 that the first Lilly representative was appointed. Those engaged in medical research are now contacted regularly. It is hoped that Eli Lilly and Company will be accorded the privilege of co-operating in the development of discoveries certain to come from the laboratories of Swiss scientists. To make available to all the findings of the world's best medical talent is the goal of Eli Lilly and Company.

LILLY INTERNATIONAL

Volume 45
Number 8

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

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PRESIDENT'S MESSAGE

THE COUNTY SOCIETY IN MEDICAL PUBLIC RELATIONS

One of the best conferences we have ever attended, from the standpoint of practical effectiveness, was the first annual conference of public relations chairmen and officers of the county and state medical societies in New Jersey held on June 13, under the auspices of the Subcommittee on Public Relations.

Thirty representatives from twelve of our twenty-one county societies reviewed in detail the public relations work of the State Society and studied an outline of a program of public service for county societies which had been formulated by the state Public Relations Committee, comprising various policies and programs approved by our House of Delegates.

A detailed report on this conference will be found on page 412 of this Journal. Your President wishes to emphasize one or two general conclusions stemming from this conference which, it seems to him, warrant our special consideration.

First, this meeting served to spotlight the fact that The Medical Society of New Jersey and its component county societies are well supplied with policies and programs, projects and purposes. We have studied all the major problems facing us, we have recognized most of our principal opportunities for public service. We have decided what we want to do about these things. The problem now—as our Executive Officer pointed out in his recent report to the House of Delegates—is to put these plans and purposes into motion, to translate our policies into actual programs of activity and service at the community level.

It seems to me that this first annual Public Relations Conference marked a milestone of progress toward this objective. For this conference was not concerned with abstract theories or pious intentions. It spent its whole time on downright practical "how to do it" discussions of such matters as the extension of our health educational services through

newspapers, schools, and radio; establishment of local plans to assure twenty-four-hour-a-day emergency service for patients needing medical attention; cancer education for physicians and the public; the need of county society leadership in improving local health department services; the immediate establishment of better plans for medical care for indigent and medically indigent patients in various categories; the organization of speakers' bureau services and the inauguration of membership promotion campaigns by the county medical societies.

If what we now need is not more policy but more execution, then it follows that the execution of our programs must be carried on primarily if not almost exclusively within the local communities and counties of our state. The coordinated plans we arrive at within our county societies and in Trenton must somehow come alive in Maple Shade, in Irvington, and in Pompton Lakes. This means that not only the county society officers but the individual members must be acquainted with these programs.

All this poses an enormous challenge to the recently inaugurated officers of the various county societies. But, by way of compensation, it offers them an opportunity to earn a special distinction for their administrative year if they will but take hold of some of our well settled objectives and concentrate upon translating them into reality at the community and county level.

In a later message, we will describe some of the plans and activities of the State Society designed to help county societies in meeting these challenges. Meanwhile, we urge every member of The Medical Society of New Jersey to read the report of our first annual Public Relations Conference, bearing in mind that every doctor of medicine is inescapably a public relations officer for the entire profession in all his contacts with his patients and the public.

J. Howard Hornberger, M.D.
President

THE AGING POPULATION

Time was when there were as many babies in a community as there were old people. Now there are six times as many old people as babies. This changing age ratio means increasing work for cardiologists, cancer specialists, psychiatrists and urologists. It does not mean less demand for pediatricians however, because as children become more rare, they will seem even more precious, and there will be increasing concern, both personal and social, over their health, nourishment and development. But to the general practitioner and to most specialists it means that a greater share of the doctor's time will be devoted to the care of chronic and degenerative diseases. The new society-sponsored Essex County Service for the Chronically Ill is a token of this shifting emphasis.

As the pharmaceutical laboratories turn out more and stronger antibiotics and other chemotherapeutic agents, there should be fewer and less severe infections. These twin changes—an aging population and less difficulty with infections—are bound to alter the face of medical practice. Hospitals will have to allot more space to chronic and degenerative diseases. Practitioners will have to equip themselves to handle these cases better, to devote more time and study to them, and to become more familiar with the many community resources which are needed in the overall management of such patients. Young physicians who are setting their sights at a specialty can do worse than to consider the possibilities of geriatrics, which, in spite of its subject matter, must surely now be ranked as the youngest of specialties.

ORIGINAL ARTICLES

CANCER AND PRECANCEROUS LESIONS OF THE SKIN*

Erich Kuznitzky, M.D., Newark, N. J.

A cross-section through the skin—omitting for practical reasons the uppermost cell-layers —shows:

(1) The basal cells, lining the rete pegs like palisades and

(2) the rete Malpighi, consisting of roundish, partly polygonal-formed cells with prickles, which connect the cells in a certain order, by means of processes. They are of protoplasmatic cell-substance and enclose small lymphatic spaces for nutrition. In contrast to these features the basal cells have no processes and are not roundish but oblong and cylindrical. There are, furthermore, the rete pegs, narrow epithelial cones, protruding into the cutis, into the connective tissue, which is lying below the epithelium. The rete pegs consist chiefly of squamous cells and are lined by basal cells. Between two rete pegs are the papilli of the cutis, consisting of connective tissue, carrying the blood vessels, lymphatics for nutrition, etc.

This is all the histology to bear in mind. If the basal cells start growing exuberantly, they protrude usually into the connective tissue, budding *downward,* not upward into the epithelium, forming a kind of cancer which consists merely of basal cells—hence the name. The basal cells in the microscopic slide are deeply stained, because they grasp the stain much more intensely than the squamous cells. They are growing along and inside the lymph-carrying vessels and lymph-spaces, in other words: they *displace* rather than *infiltrate* the underlying connective tissue. Sometimes connective tissue is pushed in front of the tumor, and cartilage and bone are destroyed by mere pressure.

Development takes a long time, mostly years; even in its worst forms, the trend of destruction is very slow, although inexorable.

Basal-cell epithelioma does not primarily occur in the mucous membrane. Sites of predilection are the head (especially the face) and trunk. Hardly any part of the body surface is exempt. Basal-cell epitheliomas may be single or multiple, and are in principle very radiosensitive.

Clinically, basal-cell epitheliomas are small, hardly visible nodules in the beginning, slightly gray. They grow slowly and peripherally, and remain superficial. The nodules are hard and they ulcerate later, cicatrize in their central part and are often covered by a crust. Under the crust, the examiner will find an erosion and perhaps scars. Sometimes they are covered by scales. In later stages the color becomes dark red, the infiltration increases, and may also involve the underlying tissue (e. g., cartilage and bone), thus leading by pressure to destruction of important organs, as ulceration of the eyelids, the eyes, ear, nose, etc.

Certain features are always found at the edges of a basal-cell epithelioma: a semi-translucent, waxy, iridescent appearance, described as mother-of-pearl-like nodules. These transparent nodules may form an edge (like a string of pearls) in the uppermost layer of the skin; this can be found by stretching the skin surrounding the edge of the epithelioma. Inspecting a larger nodule which is perhaps already ulcerative in its centre, you will find the characteristic "rolled edge", the second important sign of basal-cell epithelioma. The rolled edge frequently shows teleangiectatic vessels.

Various types of the basal-cell tumors exist. The most serious is *rodent ulcer* or *epithelioma terebrans.* It leads to skeletizing, necrotizing, and casting off bones. Even in such types metastases are not found.

The favorite location of basal-cell epithelioma is the face. Much less frequent location is the trunk. There, the tumor is slowly growing, flat, often multiple, and is usually mistaken for psoriasis, eczema, syphilis or lupus vulgaris. Those epitheliomas of the

* Read by invitation November 11, 1947, to the course for general practitioners, Polyclinic Medical School and Hospital, New York City.

trunk originate from an embryonic "Anlage"; they are nevus-like tumors.

Clinically, the most important signs are: Slow evolution, transparent, mother-of-pearl-like nodules, rolled edge, no metastases.

Histologically, the biopsy shows a well defined, true carcinoma, although it grows by displacing, not by infiltrating the underlying tissue.

Small types of no more than 1 to 1½ inches in diameter, located on places where there is ample underlying tissue, can be cured and prognosis is favorable. Any destroying or surgical method (caustic, surgical, electro-surgical, electro-coagulation, x-ray or radium treatment) can be used with success. All destructive methods are followed by an inflammatory reaction of the underlying tissue. This is essential to "dissolve" and absorb all the remnants of cells which are not otherwise destroyed.

Even in cases with favorable prognosis, no destructive method should be applied on the basis of clinical diagnosis only. Always do a biopsy.

The method of choice is surgical excision of the entire tumor. This offers several advantages:

(1) Quick elimination of the tumor.

(2) Exact histologic control to determine whether the tumor is excised in its entirety, as to width and depth. Excision should extend well into both the health epithelium and the underlying connective tissue.

(3) It defines the real type of the tumor, as to whether there is a plain basal-cell or a mixed-cell, or even a squamous-cell epithelioma; for if one of the latter has been found, thorough irradiation with x-rays or radium has to follow the surgical method, to accomplish a complete cure. In plain basal-cell tumors *one* of the above mentioned methods is usually sufficient.

In *larger tumors* which are ulcerated or cicatrized, or which involve cartilage and bones, or in the so-called trunk-epitheliomas, the therapeutic results are uncertain. A combination of two or more methods, e.g., surgical excision, or electro-coagulation, followed by x-ray or radium treatment in stronger doses should be applied. I prefer interstitial radium treatment with the drastically effective radium or radon-seeds.

SQUAMOUS EPITHELIOMA

Squamous-cell or *prickle-cell* epithelioma occurs primarily or secondarily on the skin; it is a true carcinoma in every respect, histologically as well as clinically; it spreads by metastasis, sometimes very early, and has a fatal termination. The prognosis is poor in spite of energetically applied methods. This is especially true when it is located on the mucous membranes. The commonest sites of a squamous-cell epithelioma are the mucous membranes of the tongue, buccal cavity, floor of mouth and lips. The lower lip is more often affected than the upper. It is less frequently found on the mucous membranes of the eyelids, the nose, the penis, vulva and clitoris.

The scalp, ear, and the dorsal surfaces of the hands are chiefly involved.

Its evolution is, in contrast to the basal-cell tumor, comparatively rapid. The duration of an epithelioma could be measured by months against the year-long duration of basal-cell epitheliomas.

It begins as a well defined hard nodule which soon becomes deeply infiltrated. Ulceration may occur early. When ulceration is missing, the sharply outlined lesion may become elevated, verrucous, or vegetative, especially on the hands, penis, and other parts of the genitals. Mother-of-pearl nodules are absent. Teleangiectasia is not a constant feature.

As a rule, it occurs mostly as a single lesion, especially on the mucous membranes, and affects the regional lymph-glands early.

The carriers of the changes are the squamous cells present in the rete Malpighi and its normal downward protrusions to the connective tissue of the cutis—the rete pegs. In early stages the rete pegs are prolonged, widened, and anastomosing. They contain numerous mitoses and have an intact basal-cell layer. Later, this basal-cell layer becomes disorganized and may disappear in some places. Now, the squamous cells fall in disorder, pour through the gap, gain momentum, and invade the underlying connective tissue. This gives a complete irregular picture, with anastomoses and a net-like appearance. The squamous cells retain their capacity of building up corny substance in forming the characteristic pearls or whorls. The latter consist of a central nucleus of cornification, surrounded by several onion-like rows of hyperkeratotic cells, which may sometimes calcify.

One important finding is single cells or cell-

groups in the cutis which have lost their former connection with the bulk of cells and had been *dropped down* from the epithelium. Those groups are highly characteristic and significant. They often are the first sign of malignancy in penetrating independently the cutis and subcutis by way of the lymphatics.

Changes in the cutis, which usually are missing in basal-cell epitheliomas, are of reactive nature to the powerfully protruding epithelioma: that is—an accumulation of lymphocytes and plasma-cells which together with the connective tissue build up a barrage, in order to crush the tumor-cells. Clogging of lymph-spaces by the tumor-cells can also be frequently found.

Numerous epithelial pearls and increase of connective tissue represent a comparatively low degree of malignancy. The presence of both features in a small number, but combined with numerous mitotic figures and a marked infiltrate in the cutis, indicate a relatively high degree of malignancy.

Broder's grading of carcinoma is based on the proportion of differentiated cells to the undifferentiated. Four grades are recognized in the order of malignancy:

Grade:	Differentiated cells:	Undifferentiated cells:
1	100-75 per cent	25- 0 per cent
2	75-50 per cent	25- 50 per cent
3	50-25 per cent	50- 75 per cent
4	25- 0 per cent	75-100 per cent

Diagnosis is made clinically by the rapidity of evolution, primary involvement of mucous membranes, induration of the skin-nodule, absence of mother-of-pearl nodules and of a rolled edge, and involvement of lymph-glands. These features also serve to differentiate the tumor from gummas, and from lupus. Gumma and cancer are often confused, especially when the serologic reaction is positive, but can be differentiated by adequate anti-syphilitic treatment. However, so much precious time should not be lost. Perform an immediate biopsy and examine it microscopically. The picture is so characteristic that it could not be confused with other new-growths nor with other dermatoses.

Marked *epithelial hyperplasia* could play an important role in our decision as to whether cancer is actually present. These hyperplasias with their atypic epithelial proliferation are harmless to the patient. They must be carefully differentiated from true cancer.

Prognosis depends upon grade of malignancy, location of the tumor, age of the patient, duration, involvement of the glands, radiosensitivity of the tumor, invasiveness, long-distance metastases, and upon adequate, swift treatment.

A combination of all *therapeutic methods* should be applied, in order to stop any further growth and to destroy the tumor to its roots. That includes surgical or electro-surgical methods—the latter consisting of electro-coagulation of the tumor and its bed, and all regional lymph-nodes within reach. Simultaneously, x-ray treatment (even with heavy filters like copper or zinc) of the tumor-bed and of the route of spreading should be applied. Radium can be employed by a similar technic.

If a tumor is impossible to excise by surgical methods, the application of radioactive substances should be instituted. I have seen encouraging results, even in desperate cases, with interstitial radium (or radon-) seeds combined with heavily filtered x-ray treatment while the radioactive needles are still present in the tissue of the cancer.

METASTATIC CARCINOMA

Now, a few words about secondary, metastatic carcinomas which develop in other organs and then spread by way of the lymphatics or the bloodstream to the skin. There they produce single or multiple lesions, and they are named, according to their clinical appearance, as lenticular, tuberous, etc., epitheliomas. They may become confluent and sometimes cover large areas of the skin. These include the *cancer en cuirasse,* secondary to carcinoma of the breast. This migrates along and into the lymphatics, clogging them, and may expand in the neighborhood of the breasts over a considerable area; it is accompanied by an inflammatory appearance, suggesting erysipelas.

Metastatic carcinoma usually follows the histologic structure of the organ from which it originates and in which it is primarily located. The slides of a biopsy may show the tex-

tures e.g., of prostate, breast, gall bladder, etc. The skin is merely the location for the carcinoma-metastases of other organs.

The only difficulty is this: If a tumor is primarily located in an organ, the mucous membrane of which consists of squamous epithelium (e.g., the urinary bladder or mouth), then the metastases will show the same structure as the primary tumor, namely a squamous-cell carcinoma. In such an instance it will be hard to decide whether this is a primary or a secondary carcinoma. This especially happens, when the primary (bladder, e.g.) tumor remains small and does not cause any clinical symptoms.

PRECANCEROUS LESIONS

The term *precancerous lesions* has been used by clinicians for many years to designate a group of cutaneous conditions which are followed more or less frequently by cancer. For practical reasons, we classify here the precanceroses according to the frequency with which they are followed by cancer. For instance:

(1) *Occasionally* followed by cancer: any scar, lupus erythematosus, lupus vulgaris, syphilis, chronic, long-standing ulcers.

(2) *Frequently* followed by cancer: keratoses, especially senile keratosis, farmer's or sailor's skin, kraurosis vulvae, leucoplakia, radiodermatitis.

(3) *Regularly or invariably* followed by cancer: erythroplasia, xeroderma pigmentosum, Paget's and Bowen's diseases.

Cancer developing in *scar-tissue* occurs most often in scars incident to burns. It is usually a squamous-cell cancer of a comparatively low grade of malignancy; it evolves slowly as long as it grows within the dense, sclerotic tissue of the scar, but when it reaches the normal tissue, growth may become rapid and metastasis may soon occur.

The development usually appears two or three decades after the formation of the scar, and often cancer follows some additional injury. Such patients, therefore, should be observed for a longer time, in order to detect the earliest malignant changes.

The *treatment* is the same as outlined in squamous-cell epitheliomas, unless the scar could be wholly excised and be replaced by a plastic operation.

All we have said about cancer in common scar tissue is likewise true for epitheliomas developing in scars caused by lupus erythematosus, lupus vulgaris, tertiary syphilis, chronic ulcers and fistulas.

One of the rather frequent terrains in which epitheliomas may develop, is the keratoses, often to be found in elderly people. Among those, the *senile keratosis* is the most common, typical, and dangerous precancerosis. It develops in skin showing senile degeneration. It is located on parts that are most exposed to solar radiation.

On these areas, multiple spots develop, irregular in contour, sharply outlined or blurred. They consist of a thickened horny layer, covered by a firmly adherent scale, usually of gray, brown or dull-red color. The scale exfoliates, but recurs. Sometimes they have a verrucous surface which gives a rough and dry feeling to the palpating finger.

Elevation of the spots to a greater degree is a danger signal, since this usually indicates epithelial proliferation, inflammation, and other evidence of early malignant change. Particularly dangerous is such a development on the lips, especially on the lower lip.

Single lesions that appear to be changing from keratosis to cancer should be excised as long as total excision is possible. Microscopic examination should follow. Larger lesions should be destroyed by electro-coagulation, x-rays, or radium.

Another keratotic condition is *seborrheic keratosis, senile verruca* or *seborrheic wart.* This sharply bordered round or oval lesion, elevated, of various size may have a smooth, rough or verrucous surface. Its color is yellowish-brown to black. The color is due to the waxy surface—hence the name "seborrheic" warts. It might exhibit a discoloration similar to that seen in the blackheads of the face in acne vulgaris. The scale which gives a fatty, soft feeling, can easily be removed—in contrast to senile keratosis which has a dry, rough surface-feeling and a firmly adherent scale.

Seborrheic warts need not be destroyed, because they do not develop into cancer. X-rays or radium treatment are of no avail.

Kraurosis vulvae occurs in women at the menopause or in older age groups. Small itchy red areas appear around the vaginal orifice. Soon these areas become depressed and sensitive. Later, the vaginal ostium is narrowed due to atrophy; elasticity is diminished, the tissue thin and tense, with obliteration of the natural folds. In advanced cases, labia majora and minora, and clitoris may be involved with all signs of atrophy, sclerosis, and retraction. Kraurosis is to be differentiated from scleroderma, pruritus with lichenification, and uncomplicated leucoplakia.

Leucoplakia frequently accompanies kraurosis vulvae, but is not a sign of kraurosis.It must not be mistaken for kraurosis. In uncomplicated leucoplakia there is *no* atrophy, sclerosis, and retraction. There are milky-white, dry, marginated patches, irregular in size and shape, often smooth or slightly rough. Location frequency is: vulva, mouth, tongue, lips, or any part of the mucous membrane of the mouth. Occasionally, it is also located on the penis.

Sometimes, there is a perceptible thickening; erosions, inflammation, and exfoliation are present. This is called *leucokeratosis.*

Subjective symptoms are usually absent, though there may be a burning or stinging sensation. Fissures, erosions or ulcers may develop. Those are particularly favorable as to the development of cancer, although it should be borne in mind that epithelioma may also develop in an apparently inactive patch.

Tobacco, highly spiced and very hot food and drink should be interdicted. Perfect dental hygiene and avoidance of local irritation are necessary. X-rays and radium cannot be recommended, because recurrence following irradiation is common. In widespread leucoplakia, especially in cases combined with kraurosis vulvae, drastic treatment like excision or plastic surgery, must be considered. Untoward results of radiation include *acute and chronic radiodermatitis.* The former consists of reactions of first, second, and third degrees, caused by exposure to x-rays or radioactive substances, and finally may lead to ulcers, porcelain-like atrophy with telangiectasia, sclerosis, keratoses, de- and hyperpigmentation, scars, and late ulcerations. *Chronic radiodermatitis,* (x-ray- or radium-skin) clinically resembles senile atrophic skin or xeroderma pigmentosum. Since cancer in x-ray-skin develops relatively frequently, it has to be considered a definite menace to the patient.

The cancer that may develop following radiodermatitis is usually of the squamous-cell type, of a comparatively low grade of malignancy, and is preceded by a keratosis or an ulceration. The latter may be spontaneous or the result of an additional injury.

Treatment depends on the state of the skin. When there is only atrophy with teleangiectasia, sclerosis, and keratoses, an annual observation and inspection would be sufficient. Deep-reaching and large keratoses and ulcerations, however, which do not improve or heal by palliative measures within a few weeks, should be excised or (if extensive) handled by a plastic surgeon.

Xeroderma pigmentosum shows a marked resemblance to chronic radiodermatitis. It is a rare disease, beginning in childhood, and is thought to be due to congenital lack of resistance to sunlight. The parts of the skin exposed to sun-rays are affected. The changes are the same as in radiodermatitis; however, it is a true precancerosis, always resulting in multiple epitheliomas of the basal-cell or squamous-cell type. The disease itself is incurable.

The last group of precanceroses are those which are invariably followed by epitheliomas. One of them is *erythroplasia,* in every instance followed by epithelioma of the squamous-cell type. Erythroplasia, an uncommon affection, mostly attacks the mucous membrane of the penis, occurring on the glans and the prepuce. It may be found in the mouth, on the lips, and on the vulva. In the beginning there may be one or more lesions, consisting of small, roundish, red patches with little elevation. The surface is shiny or velvety. Later they extend peripherally, in slow progress, and may unite with the adjacent lesions. Subjective symptoms are scanty: stinging or perhaps itching. Due to its serious consequences, a biopsy should be immediately done, whenever the clinical picture is suggestive of erythroplasia.

Treatment is surgical. All other kinds of

destruction (x-ray, radium, electro-coagulation) fail.

Paget's disease of the nipple and *Bowen's disease,* are supposed to be cancers from their beginning. Paget's disease is an intra-epidermal and intra-ductal carcinoma. It is encountered most frequently in the female breast around the nipple of one of the breasts and in the lactiferous ducts. It usually remains unilateral. Extramammary Paget's disease also exists, occurring on various parts of the body-surface. Paget's disease shows a well-marginated, eczema-like patch around the nipple which may be dry, scaly, exudative, eroded or crusted. A slight infiltration may be perceptible. The color of the nipple varies from pale to deep red. The patch may show a rolled edge as in basal-cell epitheliomas. Subjective symptoms are pruritus, burning or stinging sensations, or a dull ache. The patch is often but slowly progressive.

Paget's disease may be mistaken for superficial affections of the nipple such as eczema, psoriasis or lupus erythematosus. It is often impossible to establish a diagnosis from the clinical evidence alone. To be on the safe side, it is advisable to perform a prompt biopsy when there is the slightest suspicion of Paget's disease.

The microscopic picture is decisive due to the presence of numerous *Paget-cells.* These are large, vacuolated, epithelial cells with a deeply stained nucleus. The cell itself is pale. Thus, a striking microscopic picture results which facilitates the diagnosis. The same changes are seen in patches of extramammary Paget's and in the lactiferous ducts of the breast.

Diagnosis depends chiefly on the microscopic examination and the involvement of the mammary gland. Treatment consists of mammectomy and removal of the regional glands, as soon as the diagnosis is established. Thereafter radiation-treatment with filtered x-rays or radium should follow. Even without clinical evidence of involvement of the mammary gland, a thorough microscopic examination often shows an intra-ductal carcinoma of the Paget-type.

Bowen's disease occurs, as a rule, in patients over 40 years of age and is located mostly on the trunk and the extremities; but it may also occur on various parts of the body-surface and on the mucous membranes. Evolution is slow, the affection existing for several years without serious complications. An increasing number, however, are followed by cancer and metastasis. It appears as a well marginated patch and starts with a crusted or scaly papule that thickens slowly and extends peripherally. Under the scale or crust the surface may be eroded, exudative, wet or oozing, infiltrated, verrucous or cicatrized. The lesion is dull-red to dirty-brown; it may be round, oval or serpiginous. The most striking histologic feature is pronounced hyperplasia of the epidermis with a marked disorganization of the squamous cells. They show intra-cellular edema, irregularities in shape, size, and structure. Particularly characteristic is the formation of numerous epithelial giant-cells and clumped nuclei—the so-called clumping cells—and of many mitoses.

Treatment consists of surgical or electro-surgical methods, combined with x-ray or radium therapy. Early cases are easily cured in this manner.

819 South Twelfth Street

ALUMNI OF BRITISH MEDICAL SCHOOLS

Graduates of British Medical Schools are invited to participate actively in the New Jersey Chapter of the *American Alumni of British Medical Schools.* Dues are $5.00 a year, and are made payable to W. S. Schram, treasurer, and sent to Dr. Schram at 52 Liberty Street, Kearny, N. J. Phone KEarny 2-7656 for further information.

PREVENTION OF TREATMENT COMPLICATIONS IN SYPHILIS WITH NEW PARENTERAL MULTI-VITAMIN THERAPY*

PRELIMINARY REPORT

Paul Robert Kline, M.D., Trenton, N. J., and
James J. Colavita, M.D., Trenton, N. J.

The administration of multiple vitamins has become an established procedure as part of the treatment of many infections of the skin and mucous membranes. The successful treatment with vitamins of pellagrous dermatitis, cheilosis, acne, keratosis pilaris, lupus vulgaris and lupus erythematosis are well known examples. In syphilis nutritional lesions occur both as a complication of the disease itself (e.g., interstitial keratitis) and as a result of antiluetic therapy.

In our clinic, syphilis is treated either with penicillin or with arsenicals and bismuth, or with a combination of all three. Owing to present incomplete knowledge of the effectiveness of penicillin therapy in syphilis, out-patients are treated with arsenic and bismuth. Hospital patients receive an intensive combined treatment with penicillin, phenarsine and bismuth, over a 5 day period.

Penicillin has been reported as inducing vitamin deficiency. P. Ellinger and MacKenzie Shattock[1] reported in patients treated with penicillin, the development of typical symptoms of nicotinamide deficiency: lassitude, pellagroid skin changes, erythematous eruptions, thickening of the skin followed by pigmentation, clumsy gait and difficulty in balancing, abdominal distention and pain, and marked changes in the tongue. The "id" type of reaction[2] involving the skin of the hands, feet and the groin, and the urticarial reactions, polyarthralgias, edemas and giant urticarias were seen in other patients receiving penicillin therapy.

That this combined therapy may be difficult for the patient to take has been stressed by Webster,[3] who stated "It would seem that the addition of arsenic, because of its toxicity, defeats the original purpose of using penicillin". Reactions from a drug during the course of anti-syphilitic treatment are among the common causes for a patient's failing to continue treatment. Consequently, any means of avoiding or minimizing these reactions is an advantage in the management of these cases.

Because of the protective effect of vitamins on liver function, Moore[4] advocates large doses of vitamin B complex when anti-syphilitic treatment is given in the presence of impairment of the liver.

The intensive drug therapy in syphilis may cause poor utilization and storage of the fat-soluble vitamins in the body by interfering with the normal functioning of the liver. Maintenance of proper vitamin levels should be of value in preventing such reactions and later complications.

Conditions predisposing to a deficiency of one vitamin give rise to a depletion in others. Spies,[5] Jolliffe,[6] Biskind[7] and others remind us that vitamin deficiencies (as they occur in practice) are almost always multiple. An editorial in the *Journal of the American Medical Association*[8] points out that vitamin deficiency diseases rarely appear uncomplicated:

> "The resulting clinical picture seen by the physician is a complex one, and he frequently recognizes a number of distinct deficiency diseases in the same person. The patient may have a disease arising from partial deprivation of vitamin A, vitamin D, nicotinic acid amide, thiamine, riboflavin and ascorbic acid. In these deficiency states, the skin, alimentary tract and the nervous, hemopoietic and cardiovascular systems may be involved."

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* Read before the Medical Staff Conference of the Wm. McKinley Memorial Hospital, April 21, 1948. This paper is from the Division of Dermatology, Department of Medicine, McKinley Memorial Hospital, Dr. Peter J. Warter, Director.

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Large doses of any single vitamin alone may actually cause a deficiency of other vitamins. Therapy with niacin alone may precipitate manifestations of thiamine and riboflavin deficiency;[9] thiamine by itself in large doses may produce niacin or pyridoxine deficiency.[10]

With these principles in mind, and remembering the frequent association of vitamin deficiencies arising either as a contributing cause or a consequence of therapy in many of the cases treated in our clinic, we adopted for routine adjunct treatment a new parenteral aqueous multi-vitamin solution.‡ This preparation is unique in that it combines the oil-soluble vitamins A, D and E, together with the water-soluble ascorbic acid and vitamin B factors: thiamine, riboflavin, niacinamide and pyridoxine in a single aqueous solution. The lipoid vitamins A, D and E are solubilized by means of a non-toxic derivative of a sugar ester (sorbitan monolaurate derivative) which brings these fat-soluble substances into such a high degree of dispersion that the particle size becomes small enough to approach that of a true solution.

We administered injections of phenarsine and bismuth on the same day concurrently or in alternating "courses". Two cubic centimeters of the aqueous multi-vitamin solution were injected into the gluteal muscle at the same visit.

The advantage of this aqueous solution containing oil-soluble vitamins has been demonstrated, in part, by the work of Kramer et al.,[11] who showed that the intramuscular administration of vitamin A in aqueous solution produced higher blood levels of vitamin A than the same solution administered in oil; the latter in fact produced no significant rise in blood levels. Vollmer[12] has pointed out that when the lipoid vitamins in oil solution are administered intramuscularly, a long period may pass before all of a given dose is absorbed from the site of injection.

‡ Vi-Syneral Injectable, supplied by U. S. Vitamin Corporation, New York, N. Y. Each 2 cc. supplies vitamin A 10,000 U.S.P. Units, vitamin D 1000 U.S.P. Units, vitamin E (alpha-tocopherol) 2 mg., ascorbic acid 50 mg., thiamine 10 mg., riboflavin 1 mg., niacinamide 20 mg. and pyridoxine 3 mg. in aqueous solution.

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RESULTS

Intramuscular injections of the aqueous multi-vitamin formula were given to 25 patients treated in our clinic with the combined arsenical and bismuth therapy.

Twenty hospitalized patients on the ward service for rapid combined therapy of penicillin, phenarsine and bismuth were given daily injections of the vitamin preparation. These included various stages of syphilis, early, latent syphilis, congenital syphilis and one case of interstitial keratitis.

There were no significant reactions to the antiluetic therapy in any of these hospitalized or clinic cases. Conspicuously absent were the reactions noted in patients previously treated without the vitamin injectable compound. Hospital patients tolerated the anti-syphilitic treatment better, even when penicillin, phenarsine and bismuth were administered concurrently.

The entire absence of the "id" type of penicillin reaction and the urticarial and edematous reactions in patients receiving the multi-vitamin parenteral solution was in sharp contrast to the incidence of these reactions in other patients treated in the wards with penicillin alone; nor were any Herxheimer reactions noted. While our series, however, was too small to allow us to state that this multi-vitamin treatment will eliminate all reactions, the results obtained were certainly significant. No delayed reactions were reported on follow-up of our hospitalized cases, in the clinic, or at home, by a state nurse specially trained in follow-up work.

DERMATOSES

Several patients with recalcitrant dermatoses were treated with the injectable aqueous multiple vitamin preparation. The results in a few cases are worth noting.

Case 1. A 54-year old male, was first seen on December 30, 1947, with an eruption on the feet which resembled the "id reaction". It had persisted since the previous August in spite of otherwise competent treatment. Five injections of the aqueous multi-vitamin formula were given during two weeks. Additional alpha-tocopherol was administered by mouth. There was rapid improvement and an uneventful recovery. Other vitamin therapy by intramuscular route and by mouth had been

previously administered, but had not produced improvement.

Case 2. A 35-year old female was seen on September 19, 1947. She had a diffuse scaling eruption of the entire scalp and a rash on the trunk and arms consisting of slightly scaly oval patches associated with mild itching. These had been present for eight years. A tentative diagnosis of pityriasis lichenoides was made. Three injections were given at weekly intervals. The patient did not return after the third injection, but she was seen four months later. The body lesions had completely disappeared. The scalp was still slightly scaling and dry. She considered herself cured.

Case 3. Was a patient in the advanced tumor stage who had become refractory to x-ray therapy. Injections were given merely as a palliative along with nitrogen mustard therapy. He had some relief of itching at first and "felt better". Clinically there were remissions and exacerbations and the course of the disease was unchanged by this or any other therapy.

We are conducting studies with the use of aqueous parenteral multi-vitamin solution in other skin diseases, notably the dyskeratoses where other types of vitamin therapy have often failed to produce the expected results.

SUMMARY

1. Polyvitamin deficiencies are common complications of syphilis, both as a direct result of the disease itself and as a consequence of therapy. A new injectable multi-vitamin preparation combining oil-soluble and water-soluble vitamins in aqueous solution has been used in conjunction with these types of antiluetic therapy in 25 clinic patients and 20 hospital patients over a period of 8 months.

2. In sharp contrast to the incidence of complications with antiluetic therapy alone, there were no significant reactions in any of the patients who also received the polyvitamin injections. No urticarial, "id" or Herxheimer reactions occurred.

3. In addition, several patients with dermatoses long resistant to orthodox dermatologic therapy, responded dramatically to parenteral administration of the polyvitamin preparation.

178 West State Street
433 Princeton Avenue

BICHLORIDE OF MERCURY POISONING TREATED WITH SODIUM FORMALDEHYDE SULFOXYLATE

REPORT OF A CASE *

JOHN SAROKHAN, M.D., Paterson, N. J.

Since Rosenthal [1] first reported the use of sodium formaldehyde sulfoxylate in acute bichloride of mercury poisoning, there have been numerous reports on the efficacy of this drug. Notable are the papers by Wolpaw and Alpers,[2] Monte and Hull,[3] and Hug,[4] each of which presents at least twenty cases. In few cases, however, did the ingestion of the poison exceed two grams. It seems worthwhile therefore to report a case in which, despite the ingestion of almost three grams, (45 grains) the patient recovered.

A 48 year old female was admitted on May 6, 1946, because of severe vomiting. Six hours prior to admission she awoke in the middle of the night suffering from a sore throat. Without turning on the light, she ingested six tablets from a bottle in the medicine cabinet which she presumed contained sulfadiazine. Shortly thereafter she experienced an intense burning sensation in her throat and some ninety minutes later she was awakened by severe nausea. The bottle from which she had taken the medicine was found to contain a number of tablets, each representing 7.3 grains of bichloride of mercury intended for disinfecting purposes. Thus, she ingested about 45 grains (three grams) of bichloride of mercury. Egg-white was administered at home and the patient

* From the Department of Medicine, St. Joseph Hospital, Paterson, New Jersey.

1. Rosenthal, S. M.: Journal of Pharmacology and Experimental Therapy, 54:34. (May 1935).
2. Wolpaw, R., and Alpers, N.: Journal of Laboratory and Clinical Medicine, 27:1387, (August 1942).
3. Monte, L. A., and Hull, E.: Journal of The American Medical Association, 114:1433, (April 1940).
4. Hug, E.: from *Semena Medicina*, July 1938; cited by Wolpaw and Alpers, *op. cit*, reference number 2.

brought to the hospital vomiting and retching. Gastric lavage was performed, expelling bluish-blood-stained stomach contents.

FINDINGS

The patient appeared acutely ill. Gums, tongue, and mucous membrane of the mouth and pharynx had a bluish-white appearance and were injected. The abdomen was distended and tender. There was bilateral costovertebral angle tenderness. Blood pressure was 100/80. There were no other significant findings.

MANAGEMENT

During the first two hospital days eight successive urine specimens showed marked amounts of albumin and casts and gave qualitatively positive tests for mercury. The stools contained mercury. Blood pressure dropped to 70/50 during the first day. Some anasarca was noted on the second. She complained of constant soreness in the mouth, substernal distress, abdominal and low back pain, and diarrhea. On three successive days patient was given 10 grams of sodium formaldehyde sulfoxylate in 10 cubic centimeters of distilled water, administered slowly intravenously; the first dose was given six hours following the ingestion of the poison. Concurrently, she received frequent gastric lavages and colonic irrigations. Impending shock was successfully combatted by intravenous administration of human plasma and electrolytes.

During the course of the third to tenth hospital days the patient slowly improved; blood pressure became constant and normal. After the second day, mercury was no longer detected in the urine. Albuminuria persisted until the tenth day, though it was progressively less marked after the third. The soreness in the mouth, substernal distress, back pain, and bluish discoloration of the tongue, pharyngeal, and buccal mucous membranes persisted. A phenolsulphonephthalein kidney excretion test performed on the eleventh hospital day showed a 40 per cent elimination of dye after three hours; repeated on the twenty-second hospital day, the elimination was 54 per cent. The patient was discharged on the twenty-fifth day complaining only of some soreness of the gums and back pain.

A month later, she returned for observation. She was symptom-free. Phenolsulphonephthalein test showed 75 per cent elimination after three hours.

COMMENT

The response in this case following infusions of sodium formaldehyle sulfoxylate seems to substantiate the findings of Rosenthal[1] and others that this drug is efficacious in acute mercurial poisoning. The action of the drug on the absorbed fraction of mercuric ion (discussed in detail in Rosenthal's paper) makes it unique among anti-mercurials and probably accounts for its effectiveness. The drug appears to have no untoward effects and merits continued use in acute mercurial poisoning.

771 Madison Avenue

RADIO ACTIVITY AND GANGRENE

Radioactive sodium produced in the cyclotron at Columbia University has helped some 500 diabetic patients during the last three years, Beverly C. Smith, M.D., of Columbia's College of Physicians and Surgeons, reported at the American Diabetes Association.

The radioactive material, used to save legs threatened with gangrene, is injected into a vein in the arm. A radiation counter placed against the sole of the foot clicks off the amount of radiation reaching the sole from the material injected into the bloodstream. This and similar counts elsewhere on the leg give the physician knowledge of the state of blood circulation. He can then tell whether the foot might be saved even if gangrene has started, or, if an amputation is necessary, how far up the leg it must be done.

Diabetics must be taught the danger of cutting a corn or callous and of wearing shoes that raise blisters or press on corns or bunions, Dr. Smith warned. Such activities, especially if the skin is not clean and the scissors or razor not sterile, are almost certain to start the infection that requires amputation to save the patient's life.

In 40 out of 100 amputations at Presbyterian Hospital in diabetics with poor blood circulation the cause of the infection that led to gangrene and loss of a leg was cutting of or shoe pressure on a callous, corn, nail or bunion.

HAY FEVER

PANEL DISCUSSION, NEW JERSEY ALLERGY SOCIETY *

1. ETIOLOGY

CLIFFORD G. WESTON, M.D., GLEN RIDGE, N. J.

To produce hay fever, each type of pollen must meet three criteria: (a) be produced in abundance, (b) have buoyancy, and (c) have the ability to provoke toxic reactions in human beings.

(a) Abundance of pollens is almost universal among trees, flowers, grasses and weeds.

(b) Buoyancy enables the pollens to be carried great distances—several thousand feet through the air and over many miles at sea.

(c) It is the toxicity of the pollen which provides the entering wedge for the clinical manifestations of hay fever.

The windborne pollens which are capable of producing a toxic response in human beings are from the shade trees in the early spring, grasses and plantain in the summer, and ragweed in the fall. The garden flowers such as cosmos, asters, dahlias and cultivated corn have heavy, sticky, toxic pollens which produce symptoms only by close contact.

Ragweed differs somewhat in form in various sections, but extends from the Atlantic to the Pacific coastal range and from Canada to Cuba. The individual pollen grains are microscopic in size and have definite contour characteristics making them easily recognizable in stained specimens. Those of the nonwindborne types are somewhat larger and much more spiny and irregular in outline than the windborne varieties.

2. DIAGNOSIS

JOSEPH SKWIRSKY, M.D., NEWARK, N. J.

The clinical diagnosis of hay fever is not difficult. The seasonal recurrence of the characteristic symptoms of sneezing, rhinorrhea, and ophthalmic manifestations in the late spring or early summer in most cases enables the layman to make his own diagnosis. But in many instances a good, detailed, careful history is of the utmost importance.

First, find out approximately the dates of onset and cessation of the symptoms, duration in years, the time of the greatest intensity of the suffering, and whether there have been any free years. We should also determine where these patients spend their time during the season; whether their symptoms are worse indoors or outdoors, day or night, when they are exposed to animals, dusty places, or dusty bedding.

Occasionally symptoms are due to environmental rather than seasonal factors.

The three hay fever seasons roughly correspond with the following dates. If symptoms occur at the end of March, April, or early May, trees should be suspected. If symptoms begin at the end of May and last to about mid-July, grasses and English plantain are most likely the cause. Then there is the usual interval until the middle of August when the late (ragweed) season begins and lasts until frost.

Next to the history and physical examination in the diagnosis of hay fever, is the testing. Testing can be done by the scratch intradermal or ophthalmic methods.

I prefer the intradermal route because it gives the best information about the degree of sensitivity, in order to graduate the doses of treatment.

The reactions are designated as "marked," "moderate," "slight," and "negative." Sometimes we qualify them with plus or minus, "moderate to marked," and "slight to moderate."

Patients are roughly divided into four classes. Class "A"—if patient gives a marked reaction to the 10 unit strength. If slight or moderate to the 10 units but marked to the 100 units strength the patient is called "B". If it requires 500 or 1000 strength to elicit a marked reaction he is put into Class "C". Patients who give only a moderate reaction to the 2000 or 5000 units are in Class "D"—relatively insensitive.

We should also mention a "non-skin-reacting-group." These patients give entirely negative skin reactions (or at most slight to 5000 or 10,000 strength), but have symptoms corresponding to hay fever seasons. I treat these patients for at least one year. They usually require

* From a meeting of the N. J. Allergy Society, held in Newark, N. J., May 12, 1948. Papers as presented here have been abstracted for the JOURNAL by Frank L. Rosen, M.D., chairman of the publication committee of the N. J. Allergy Society.

large doses of pollen (up to 20 or 30 thousand units), favorable results are often obtained.

3. SPECIFIC TREATMENT
FRANK L. ROSEN, M.D., NEWARK, N. J.

Pollen injection still remains the treatment of choice in hay fever. Principles of successful pollen treatment are the same whether the hay fever is caused by allergy to trees, grasses or weeds. For example, take the most common form of hay fever in this area, that which produces symptoms from approximately August tenth to the first frost—ragweed.

Pre-seasonal Therapy has the widest usage. Injections are started six to twelve weeks before symptoms are expected. The degree of sensitivity to ragweed pollen is ascertained (either by scratch intradermal or ophthalmic tests with dilution of pollen), together with the patient's history. He is given increasing subcutaneous injections of pollen extract, reaching maximum dose just before the onset of the expected symptoms.

Each patient is an individual problem. No rigid dosage schedule can be maintained. With proper dosage, good extracts and a reasonable pollen count, 80 per cent of patients will get excellent relief from their hay fever symptoms, and complications like asthma and sinusitis will occur only one tenth as often in the treated patient.

What are the reasons for poor results in this form of therapy?

A. *Dosage too high*—after one or two constitutional reactions, the patient stops treatment.

B. *Dosage too low*—Hypo-sensitization does not take place.

C. *Unusually high pollen count*—For example, a patient from Newark may visit Indiana about Labor Day, be exposed to much more ragweed pollen.

D. *Presence of other allergies*—Food allergies or other inhalant allergies may be present. In some cases these can be subclinical during the rest of the year, but their symptoms are exploded by the ragweed trigger. If any hay fever patient is not getting a good result, he should be completely tested.

Co-seasonal Treatment does not produce results as consistently as pre-seasonal treatment. Much smaller doses of pollen are used at more frequent intervals than in pre-seasonal treatment. Some allergists use intradermal injection rather than subcutaneous in this form of treatment.

Perennial Treatment is a procedure in which injections are continued every three or four weeks throughout the year, the dose being about half the maximum pre-seasonal dose reached. Many allergists feel that this gives better results than pre-seasonal treatment alone.

4. NON-SPECIFIC TREATMENT
LOUIS BYCK, M.D., NEWARK, N. J.

Any treatment of hay fever other than specific hypo-sensitization, must be considered as supplemental therapy only. Specific treatment is still the best single method for handling pollenosis and its complications. Major interest at present centers around the procession of new antihistaminic drugs. However we must not abandon the older remedies which still offer relief to seasonal sufferers. The autonomic drugs like epinephrine, ephedrine, and similar preparations, yield uniform results. Their greatest value is in the treatment of asthma complicating hay fever, and (in topical applications) for nasal and eye symptoms. For immediate relief of the "asthmatic seizures" so often associated with pollenosis, ephedrine remains our best drug. Also helpful in the pollen asthmatic are iodides by mouth and aminophyllin intravenously and rectally.

Amphetamine in inhaler tubes gives some relief from nasal clogging. Abuse of these drugs, besides producing undesirable side-effects (nervousness, tachycardia, palpitations, etc.) may actually aggravate the nasal clogging. The familiar rebound reaction following the immediate vasoconstriction can set off a vicious cycle. In many uncomplicated cases of pollenosis, the patient abuses his nose drops and continues this form of medication long after pollination has stopped. The simple expedient of stopping the drops would, after one or two days of discomfort, eliminate the nasal complaints.

Atropine is useful in controlling the rhinorrhea. A prescription containing atropine, ephedrine and aspirin has given gratifying results. Codeine may be added if there is an associated cough. Inquiry about aspirin sensitivity should always be made before pre-

scribing salicylates for any allergic individual.

An excellent eye drop prescription is:

Cocaine hydrochloride	0.01
Boric acid	1.
Adrenalin 1:1000	8.
Rose water qs	30.

This preparation will relieve the annoying eye symptoms. A widely used proprietary "estivin" has also been helpful.

It is now about two years that we have had access to the first of the *antihistaminic drugs,* benadryl. This was followed in October 1946 by pyribenzamine. Since then many new drugs have made their appearance. The common factor in these preparations is their varying ability to prevent (or diminish) the pharmacologic effects of histamine. The best drug will be the one whose ratio of therapeutic efficiency to toxicity is most favorable.

The mode of action of these drugs is of interest. Direct chemical combination with and neutralization of histamine, or prevention of the antigen antibody reaction, is not generally considered the likely mode of action. The evidence suggests that the antihistaminics have a greater affinity for the receptor cells and thus block the disrupting action of histamine.

To date, because of their earlier appearance (not necessarily because of any greater therapeutic value) benadryl and pyribenzamine have been the subject of most of the reports and therefore the following statistics have been based primarily on studies of these two drugs.

About 75 per cent of subjects taking these drugs during the hay fever season experienced relief within half an hour after an oral dose of 50 milligrams. In hay fever, the sneezing, coryza and itching are the symptoms most markedly relieved. Intranasal edema responds less readily. Asthmatic symptoms are usually poorly controlled by antihistaminics. Combinations of these drugs with ephedrine or aminophyllin or both, yield a better response. Hydryllin, (a combination of benadryl and aminophyllin) has given figures of effectiveness in asthma more impressive than those of other antihistaminics: 51 per cent of 397 cases of asthma had either good or fair relief.

Side reactions occurred in about a fourth of the patients receiving pyribenzamine and in about 60 per cent of those taking benadryl. Levin lists 23 side effects. He stated the symptoms produced by the drug were severe enough in about one half the patients who had reactions to warrant discontinuance of the drug. The side reaction most commonly encountered after the administration of benadryl was a combination of drowsiness, inability to concentrate, mental confusion and narcolepsy. Less common complaints were gastrointestinal upset, dryness, dizziness, numbness of lips and tongue, blurring of vision, and palpitation. The side effects of pyribenzamine seen most frequently were gastrointestinal upsets, sedation, dizziness and headache.

There have been reports of major side effects of disorientation, marked excitation, convulsions, circulatory collapse and unconsciousness. One case of granulocytopenia probably due to pyribenzamine has been reported. Although as much as 1200 milligrams of pyribenzamine has been given a patient in a period of 24 hours without any demonstrable toxicity, it is important to keep in mind Feinberg's warning that the possible remote toxic effects from antihistaminics are not yet fully ascertained. Loveless finds that most of the side reactions are of mild intensity, requiring no treatment other than the discontinuance of antihistaminic therapy. She believes the incidence and severity can be reduced by prescribing food or sugar to be taken with the drugs, also by the use of some mild stimulant such as caffeine or amphetamine to negate sedation.

Antihistaminic drugs are generally administered orally in the form of capsule, tablet or liquid. Usual dose for adults of most of these drugs is 50 milligrams, repeated in three or four hours when necessary. Dosage for children (under 10 years) is 25 milligrams but larger doses may be used if smaller amounts are ineffectual. For infants, 10 to 20 milligrams, carried in the elixir may be used. Logan has found the safe effective dose in infants about 2 milligrams per pound body weight. These drugs are solely palliative forms of medication. A dose may be effective for several hours, but there is no prolonged residual action after the drug has been discontinued. It is foolhardy to have a patient take such a drug for weeks or days preceding the onset of a hay fever season.

At present I have in my office the following preparations: benadryl, pyribenzamine, neoantergan, histadyl, thenylene, trimeton, hy-

dryllin, neo-hetramine, diatrin and thephorin. I have seen reports on chlorothen, bromothen, decapryn, antistine and anthallan. How is one faced with this array to decide which drug to use? Regardless of scattered reports, the efficacy of these drugs in individual cases will be a process of "trial and error".

Our usual guide in the selection of new drugs is, of course, the American Medical Association's valuable compendium, *New and Non-Official Remedies*. However, the new preparations come out of the laboratory faster than the printing presses can turn out copies of this book; and even the hard-working Council on Pharmacy and Chemistry can not, in its deliberation on acceptance and rejection, keep up with the pace of new drugs in this field. Fortunately, the American Academy of Allergy has a committee evaluating these preparations. They use the services of a truly outstanding pharmacologist who first considers each drug for toxicity, then for therapeutic effectiveness. If the new preparation is passed by him, it then runs the gamut of the committee, made up of six Fellows of the Academy who provide a further screening. If it shows possibilities, it is given an extensive and nationwide clinical trial, results of which are reported. This is a time-consuming procedure, but the safety and welfare of our patients is adequate justification for the delay. An example of the wisdom of this cautious procedure is the experience of one allergist who enthusiastically submitted three patients to a new drug, only to see all three of them develop major convulsions.

Clinical experience indicates that the antihistaminic drugs are of value in the treatment of hay fever. But their greatest value is as a supplementary measure to the fundamental procedure of specific desensitization.

NEW JERSEY ALLERGY SOCIETY
William Greifinger, M.D., Secretary
31 Lincoln Park, Newark 2, N. J.

PYRIBENZAMINE FEVER

REPORT OF A CASE

S. J. Fanburg, M.D., Newark, N. J.

Side reactions due to the administration of pyribenzamine, such as headaches, drowsiness and nausea, have been reported, but I have been unable to find any reference to *drug fever* following its use. I therefore place on record this case in which it is fairly certain a fever was produced by pyribenzamine.

On January 20, I saw a 28 year old male who had a generalized exfoliative dermatitis, secondary to psoriasis. He complained of a general pruritus for which pyribenzamine was prescribed. He took 50 milligrams every four hours during the day and 50 milligrams at bedtime. He continued this dosage for three weeks. He felt a sensation of warmth most of this time, but his temperature was not taken until February 13, when it was found to be 102 by mouth. The next day it was 105. At that time the pyribenzamine was discontinued. No other medication was being taken. On February 16, temperature was normal. General examination failed to reveal any infection or other cause for the fever. On February 17, he entered a hospital for treatment of the exfoliative dermatitis. During the three weeks stay in the hospital the temperature was always normal. No pyribenzamine was used during this period.

On March 20 he complained of some itching again and he was advised to take pyribenzamine. At 11 a. m., 1 and 3 p. m. he took a 50 milligram tablet. At 6 p. m. his temperature was 102. At 9 p. m. it was 104, no more of the drug was taken, and the following morning, the temperature was normal and has remained normal ever since. Examination of the nose, throat and chest at the height of the fever was negative.

The abrupt onset of the pyrexia, its equally abrupt termination, and the fact that pyribenzamine is eliminated from the body in six hours would indicate that the drug was responsible for the fever.

31 Lincoln Park

COMPULSORY TREATMENT OF THE NARCOTIC ADDICT

Garland H. Williams, District Supervisor,
U. S. Bureau of Narcotics, New York, N. Y.

Addiction to narcotic drugs is a dangerous social and economic problem in many sections of New York and New Jersey. Particularly is it serious in the metropolitan area of New York City and in several of the larger cities in northern New Jersey. The evils connected with narcotic addiction affect not only the individual but reach into the lives of many members of the community in which addicts operate. It is a community problem and can best be solved by appropriate legislative action by the states.

In general, there are two types of narcotic addicts: *The medical addict* who is sick, under the professional care of a physician who has legally determined that narcotic drugs are medicinally required in the treatment of the disease, and the *criminal addict* who has no recognized medical need for the drug and takes the drug only to satisfy his destructive craving, and in order to carry on his criminal activities.

Federal and state laws adequately provide the required controls over the dispensing of drugs to *medical addicts* and physicians are in no way prevented from prescribing or administering the proper amount of narcotics to bona fide patients. The medical addict is not concerned with the problem discussed herein.

The criminal addict is the problem which confronts us and a practical solution is urgently needed. These parasites on a community are engaged in all types of crime. Their addiction is a result of their life of crime, and can be supported only by a continuation of their illegal activities. Addicts make addicts of their associates and the final solution of the problem rests upon our ability to cure these persons of their craving. A narcotic addict is incapable of forcing himself to undergo treatment for his addiction and *he will never complete a cure unless he is placed under some form of compulsion.*

Several states have recognized the need of narcotic addicts for proper medical treatment and have enacted laws which require that such persons enter an approved hospital for treatment. In those states the narcotic problem is of minor importance and the criminal addicts avoid such states as they would the plague. The taxpayers of those jurisdictions are therefore not required to support and maintain elaborate narcotic law enforcement organizations of the federal, state and municipal governments. *In New York and in New Jersey there are no laws requiring an illegal addict to submit to a cure* and in all truth this area is considered to be a refuge and a happy ground for these criminal characters. In New York City, the federal government and the municipal government are forced to maintain very large and expensive police, investigative and judicial units for the sole purpose of controlling the traffic in narcotic drugs. This traffic would not exist if addicts could be required to accept a cure. The answer to this narcotic addiction problem is obvious—*the addicts must be cured.*

In the 1947 session of the New York State Legislature a bill providing for the compulsory treatment of narcotic addicts was introduced. The bill passed both houses but was not approved by the Governor. The bill was as follows:

> Any person who habitually uses narcotic drugs, as defined in section 421 of the Public Health Law, or is found to be addicted to such drugs, or is found to be under the influence of such drugs, except as hereinafter provided, shall be guilty of a misdemeanor, and shall be sentenced to imprisonment for a term of not less than that required to effect a medical cure of the addiction and not more than one year; provided that in its discretion the court may place such person on probation conditioned upon such person entering an institution approved by federal, state or municipal authorities for the treatment of narcotic addicts, and remaining in such institution until certified by proper medical authorities as being cured.
>
> Nothing in this section shall be applicable to a person who has a medical need for narcotic drugs and who obtains the drugs required for such medical need in accordance with state or federal laws.

Legislation such as that quoted above is designed to give to criminal addicts the modern

physiologic and psychologic treatment now available in the United States Public Health Service hospitals at Lexington, Kentucky, and Fort Worth, Texas. If these addicted persons can be sent to such institutions and required to complete a proper medical cure, there is greater hope that they can make the personal adjustments required if they are to leave their lives of crime. Unless these criminal characters can be forced to accept a cure we will have them with us always and must continue to suffer from their anti-social behavior. The bill as written *carefully excludes from its application all persons who secure their drugs legally* and would in no way affect the unfortunate sick who have a true medical need for narcotics. It is applicable only to persons who violate the laws and who secure their drugs illegally. It is aimed solely at our underworld and will be a powerful factor in reducing crime in our communities. Such legislation is urgently needed.

90 Church Street

EXAMINATION FOR USPHS

A competitive examination for appointment in the United States Public Health Service in the grade of assistant surgeon (first lieutenant) and senior assistant surgeon (captain) will be held in October. The written examination will be conducted October 4, 5 and 6 at places convenient to the candidates. The oral examination will be held at various points throughout the country.

All applicants must be citizens of the United States, must present a diploma of graduation from a recognized medical school and pass a physical examination performed by Public Health Service officers.

Physicians beginning internship on July 1, 1948, will be admitted to the examination. Successful candidates will be placed on active duty in the Regular Corps upon completion of internship on July 1, 1949.

Applicants for the grade of assistant surgeon must have had at least seven years of educational and professional training or experience, exclusive of high school. Applicants for the grade of senior assistant surgeon must have had at least ten years of educational and professional training or experience, exclusive of high school.

Entrance pay for an assistant surgeon with dependents is $5011 a year and for senior assistant surgeon with dependents $5551 a year. This includes the additional pay of $1200 for medical officers, as well as subsistence and rental allowance. Provisions are made for promotions at regular intervals up to and including the grade of senior surgeon (lieutenant colonel) and for selection for promotion to grade of medical director (colonel) at $9751 a year. Retirement is authorized at either completion of 30 years' service or at the age of 64. Full medical care including disability retirement at three-fourths pay is provided.

Application forms may be obtained from the Surgeon General, United States Public Health Service, Washington 25, D. C.

THE NUMBER 1 CASE FINDER

The most important of all case-finding agencies in the fight against tuberculosis is the practicing physician. The family physician has the first opportunty not only to ascertain the presence of tuberculosis among the people, but also to give battle for the cure of the afflicted and to safeguard the other members of the family from the tubercle bacillus. For it is the family physician to whom most people go when troubled by signs of ill health.

GENERAL HOSPITALS AND CONTAGIOUS DISEASES

General hospitals should admit all contagious diseases that need hospital care. This would eliminate expensive contagious disease hospitals that are practically empty half the time. Tuberculosis is becoming more and more a responsibility of the general hospital as the disease is detected earlier and treatment is much the same as for any other acute illness. Graham L. Davis, Bull. Am. Coll. Surgeons, (1948).

CARCINOMA OF THE GALL BLADDER

SAMUEL M. GILBERT, M.D., Newark, N. J.

This is a report of two cases of primary carcinoma of the gall bladder years after the removal of the stones by cholecystostomy. It reinforces the conviction that removal of the gall bladder is the operation of choice in proved gall bladder disease. Some authors believe that the 1 to 2½ per cent risk of carcinoma is no greater than the mortality from cholecystectomy in major clinics (Allen and Wallace 1.8 per cent, Cheever 1.12 per cent, Graham 1.56 per cent, Whipple 0.78 per cent). But this risk added to the non-malignant complications of gallstones, notably acute cholecystitis and common duct stone makes the argument in favor of cholecystectomy versus cholecystostomy the more convincing.

Carcinoma of the gall bladder occurs most often in women. Cases have been reported from the ages of 22 to 78, most of them in the 55 to 65 age bracket. I reviewed the last 1223 cases of gall bladder operations at the Newark Beth Israel Hospital. The diagnosis in all cases was established by the pathologic report. The laboratory diagnosis was cholelithiasis in 916 cases, cholecystitis without stones in 292 cases, and cholesterosis in 15 cases. In this series there were 24 instances of primary carcinoma of the gall bladder, or 1.9 per cent. All cases of carcinoma were in females.

ANALYSIS OF 24 CASES OF CARCINOMA OF THE GALL BLADDER

Age	*Operative Findings*	*Pathologic Findings*	*Jaundice*	*Gall Bladder Attacks*	*Palpable Mass*	*Miscellaneous Notes*
65	Empyema Calculi	Infiltrating Adenocarcinoma	None	25 years	Liver Enlarged	X-ray of colon negative
59	Calculi	Infiltrating Adenocarcinoma	Moderate	1 year	No	Icteric Index 40
63	Calculi Adhesions	Infiltrating Adenocarcinoma	None	5 years	No	Intermittent pain became continuous.
52	Thickened G.B. Calculi	Mucous Adenocarcinoma	None	18 years	No	
70	Empyema Calculi	Infiltrating Adenocarcinoma	None	No	No	Diagnosed Acute Appendicitis
48	Calculi Adhesions	Infiltrating Adenocarcinoma	Moderate	5 months	No	No visualization Triple dose dye
65	Empyema Calculi	Infiltrating Adenocarcinoma	Yes	30 years	No	Cholecystostomy G.B. friable
72	Peritonitis Calculi	Adenocarcinoma	Severe	11 years	Yes	Cholecystostomy Neg. flat film
34	Edematous	Infiltrating Adenocarcinoma	None	10 years	No	
62	Adhesions Calculi	Infiltrating Adenocarcinoma	Severe	10 years	Yes	30 lb. weight loss
65	Adhesions Calculi	Infiltrating Adenocarcinoma	Severe	30 years	Yes	20 lb. weight loss
62	Empyema Calculi	Adenocarcinoma	Severe	17 years	Yes	Non-visualization by x-ray
61	Empyema Calculi	Infiltrating Adenocarcinoma	None	1 week	No	Neg. flat film Acute history

54	Cholecystitis Calculi	Papillary Carcinoma	Moderate	3 weeks	No	No visualization Double dose dye
58	Cholecystitis Calculi	Medullary Carcinoma	None	20 years	Yes	Increasing pain and number of attacks
72	Calculi	Schirrous Carcinoma	Moderate	3 weeks	Enlarged G.B.	Obstructive Jaundice Cholecystostomy
47	Adhesions Calculus	Medullary Carcinoma	None	3 years	Yes	Steady pain three weeks
72	Gangrenous	Adenocarcinoma	Severe	1 year	Yes	Persistent pain 4 weeks. Stones seen flat plate.
52	Adhesions Calculi	Infiltrating Adenocarcinoma	None	1 year	Yes	
76	Empyema Calculi	Adenocarcinoma	None	3 years	Yes	
47	Gangrenous Calculi	Adenocarcinoma	None	18 years	G.B.	Sudden acute attack
60	Stony hard Calculi	Adenocarcinoma	Severe	1 year	No	32 lb. weight loss Non-visualization
50	Empyema Calculi	Schirrous Carcinoma	None	5 years	Yes	Non-visualization Case 1.
56	Calculi	Infiltrating Adenocarcinoma	None	22 years	No	Case 2.

Carcinoma rarely occurs in a healthy gall bladder. The association of gallstones and carcinoma has been stressed by all authors. The reported ratio varies from a low of 48.5 per cent by Seide and Geller [2] to 88 per cent by Warren [1] at the Massachusetts General Hospital. In the 24 cases charted here it will be noted that every patient had a proved associated cholelithiasis. Seide and Geller experimentally introduced human gallstones into the gall bladder of animals and found that some developed infiltrative tumors. This was in line with Virchow's theory of chronic irritation. Lotzin believes that both cholelithiasis and primary carcinoma of the gall bladder have a common origin in the toxic, infectious, and metabolic disturbances of the elements of the bile. Fischer-Wasel's theory is that chronic regeneration in the gall bladder due to irritation by stones leads to a tumor mass. Burrows [3] however could not produce a single tumor mass in 33 guinea pigs into whose gall bladders he introduced human biliary calculi. We must conclude that a review of the histories of most cases reported in the literature as well as those in my own series, reveals that cholelithiasis preceded the finding of carcinoma in the gall bladder. Surely these patients did *not* have a malignancy for so many years since carcinoma in this organ is rapidly fatal in most cases.

The onset of carcinoma is insidious taking its course in the guise of cholecystitis or cholelithiasis. In 13 of the reported 24 cases, either empyema or marked inflammatory disease was found at operation in addition to gallstones and carcinoma. The diagnosis of carcinoma is rarely made preoperatively but one should think of it when a patient past 50 who has had biliary colic attacks suddenly complains of continuous pain and begins to lose weight. The most important physical finding is a hard mass palpable in the right upper quadrant. This was present in ten of this series of 24 cases. Jaundice varies but is a fairly frequent sign. It depends on the association of either direct involvement of the bile ducts by carcinoma or pressure on the ducts. Jaundice was present in 11 of the 24 cases reviewed here. Roentgen examination of the gall bladder always results in a non-visualization of the organ but occasionally the flat plate of the abdomen shows gallstones.

1. Warren, R. and Balch, F.: *Surgery*, 7:657 (May 1940).
2. Seide, J., and Geller, W.: *Arkives vor Verdauungskrift*, 54:71 (1933).

At operation the commonest finding is the schirrous type of adenocarcinoma, the diffuse, flat, infiltrating type of Ewing. It begins as a localized induration of the wall. There is a cartilaginous feel to the tissue and it may be mistaken for chronic cholecystitis. Another type is the villous, papillary adenocarcinoma which grows into the lumen as a cauliflower-like mass. The least common is the gelatinous, mucoid or colloid type which consists of a jelly-like mass of mucin-filled cells.

Prognosis is poor because of the early extension via the lymphatics to neighboring organs especially the ducts and the liver. Most patients die in six months, but Warren [1] reports a woman living 2½ years after operation and Finney [4] one surviving 25 months.

Lichenstein [5] reported 75 patients, of whom four had cholecystostomies from five to sixteen years before the operation which disclosed carcinoma. Finney lists eighteen cases of carcinoma of the gall bladder in 1.192 gall bladder operations (1.5 per cent) two of whom had previous cholecystostomies one to five years previously. In all these cases the stones had recurred at the time of the second operation. Two such reoperated cases are reported here:

CASE ONE

Female, aged 50, was first seen by me in 1940. At that time she had a history of pain in the right lower quadrant, nausea, vomiting, with exquisite tenderness over McBurney's point. A diagnosis of acute appendicitis was made. At operation by Dr. Edwin Seidman the appendix appeared normal, but an acute cholecystitis with cholelithiasis was found in a ptotic gall bladder. Because of difficulty with the anesthesia, in this very obese patient a rapid cholecystostomy was performed with removal of all calculi and tube drainage. The patient made a good recovery, and was apparently well until March 1945.

She then began to complain of a mass in the operative wound. An incisional hernia was found and repaired by Dr. Harold Hantman on September 13, 1945. Omental adhesions were present in the old wound at operation. Following the operation, she suffered continuous pain in the right upper quadrant, some loss of weight, but no nausea or vomiting. A large mass was palpable beneath the wound to the right of the umbilicus. The mass was slightly tender and did not move with respiration. Barium enema study was negative. A gall bladder visualization was attempted but no dye was seen to enter the gall bladder. At operation by Dr. Harold Hantman on November 5, an empyema of the gall bladder was found with rupture of the organ into the small bowel. The entire mass was adherent to the cecum and ascending colon. The gall bladder was removed and the intestinal perforations repaired. The patient went into shock and died two days postoperatively. The pathologic report was "gall bladder tissue containing two calculi with a growth in the wall of the gall bladder; diagnosis: ulcerating carcinoma of the gall bladder with extensive necrosis".

CASE TWO

A 56 year-old woman had a cholecystostomy twenty-two years ago for gallstones. She was apparently well until 1943 when she developed symptoms of biliary colic, diabetes mellitus, and auricular fibrillation. She was referred to me by Dr. S. C. Frank for relief of continuous right upper quadrant pain relieved only by morphine. She had lost fifty pounds in weight due to fear of eating and constant distress. The diabetes was controlled by ten units of insulin daily. Gastro-intestinal study revealed a normal stomach and intestinal tract. The gall bladder was not visualized with a double dose of Priodax tablets. No radio-opaque calculi were evident. Her cardiac reserve was studied and, despite the auricular fibrillation, I felt the patient could withstand a rapid cholecystectomy. She was operated on by Dr. Charles Robbins and a distended gall bladder filled with stones was found. Moderate adhesions were present. The gall bladder was easily removed, and the patient made an uneventful recovery. The pathologic report was schirrous infiltrating adenocarcinoma of the wall of the gall bladder. Three facetted stones were present. The patient is now perfectly well, free from pain, and gaining weight.

CONCLUSION

1. Two cases of carcinoma of the gall bladder are reported in patients who had cholecystostomies five and twenty-two years previously.

2. Twenty-four cases of carcinoma of the gall bladder are summarized. Cholelithiasis was associated in all cases.

3. Patients with recurrent attacks of cholelithiasis should be operated on especially when approaching the age of increased carcinoma frequency. Cholecystectomy is definitely the operation of choice. However if for any reason cholecystostomy has been performed, a secondary cholecystectomy is advisable after a very short interval because of the almost certain recurrence of cholelithiasis with its attendant dangers or the development of carcinoma.

3. Burrows, Harold: *British Journal of Surgery*, 20:607 (April 1933).
4. Finney, J., and Johnson, M.: *Annals of Surgery*, 121:425 (April 1945).
5. Lichenstein, G., and Tannenbaum, William: *Annals of Surgery*, 111:411 (March 1940).

144 Clinton Avenue

DANGERS IN THE USE OF PENICILLIN IN DIPHTHERIA AND OTHER UPPER RESPIRATORY INFECTIONS

WILLIAM STEIN, M.D., New Brunswick, N. J.

Diphtheria has become more prevalent during the war and immediate postwar period. However, it is still far less common than ordinary nasopharyngitis or tonsillitis, and it is easy to see how an upper respiratory infection caused by the diphtheria bacillus would be hastily classified as "ordinary" pharyngitis. Such a diagnostic error, though understandable, may cause heartache to all concerned. Apart from the failure to use antitoxin, there is the positive danger of using penicillin, thus masking the diagnosis, giving the toxin a chance to spread.

The *corynebacterium diphtheriae* is susceptible to penicillin, at least "in vitro". Many observers [1] have found that the drug inhibits the growth of the diphtheria bacillus. But—and this is the important point—*penicillin does not exercise any influence on the diphtheria toxin.* Thus, the organism may be inhibited perhaps to the point of a negative smear or culture,—yet if the toxin has been permitted to go unchecked, the net result is a clinical diphtheria, all the more dangerous because it has been masked.

Does penicillin exercise any topical effect on the diphtheria organism? Many workers [2] insist that the drug is effective topically in the treatment of carrier states. On the other hand, Paul and his colleagues [3] were not at all impressed with the capacity of penicillin to reduce the carrier state of virulent diphtheria bacilli by nebulization and inhalation. However, in their remarks they qualify their conclusion by stating "in an attempt to explain our failures in clearing up diphtheria carriers by the use of nebulized sprays of penicillin solution, it has occurred to us that possibly our solutions were too highly nebulized or that the concentration of our penicillin solutions was too low. Higher concentrations and a less minute droplet type of spray may possibly be more effective." Their in vitro tests indicated that some strains of diphtheriae are penicillin sensitive while others are penicillin tolerant. Forty-one out of sixty-four cultures were penicillin sensitive. The frequency of sensitivity in this series was 64 per cent.

Karelitz [2] makes the only favorable comment relative to the use of intramuscular penicillin in the treatment of the diphtheria carrier state.

In the treatment of acute diphtheria Weinstein, Karelitz, Petersen,[2] and De *et al* [4] agree that penicillin should not be used in place of antitoxin.

The early diagnosis of diphtheria is essential to avoid its complications and possible loss of life. The diphtheria bacillus is found on the surface of the affected mucous membranes if sought for properly. Diphtheria membrane, if present, must be pried loose and the culture swabbed directly from the mucous membrane. The organism has only slight capacity to invade the body. The harm produced by the disease is due to the soluble toxin elaborated by the organism and absorbed from the surface of the mucous membrane affected. Diphtheria antitoxin must be given within the first four days of infection in order to prevent subsequent complications due to the destructive action of the toxin.

Unless the physician is "diphtheria-minded", there is real danger of his confusing nasal and faucial diphtheria with common nasopharyngeal and tonsillar infections. Do not expect that diphtheria will always give the classical picture of "redness of the throat, flakes at various points which ultimately become confluent to produce a slightly elevated, dull, opaque, layer, tenaciously adherent to the underlying tissue, that leaves a raw blood ooz-

1. Chain, E., *et al*, Lancet, 2:226 (Sept. 1940); also Abraham, E. P., *et al*, Lancet 2:177 (Aug. 1941) and Fleming, A., British Medical Journal 1:547 (Nov. 1942).
2. Kocher, R. A., and Siemsen, W. J.: Annals of Internal Medicine, 24:883 (May 1946) and Weinstein, Louis, American Journal of the Medical Sciences, 213:308 (March 1947) and Karelitz, S., *et al*, Journal of Pediatrics, 30:18 (January 1947) and Petersen, R. L., Archives of Otolaryngology, 45:298 (March 1947).
3. Paul, R.; Tucker, S.; Holladay, B., and Nicewonger, C.: Annals of Internal Medicine, 24:413 (March 1946).
4. De, M. N.; Chatterjc, J. R., and Ganguli, L.: British Medical Journal, 1:376 (March 1947).

ing surface when peeled off over which a new false membrane quickly forms". The local lesion may be mild and only catarrhal in character.

Should the infection be mixed as with streptococci, the latter may show inflammation peculiar to it with reddening of the mucosa, tonsillar swelling, patches of whitish or yellowish-white necrotic material which when removed may leave deep, raw ulcerations. It may cover the surface of the tonsils like a membrane. These findings may be indistinguishable from those due to diphtheria.

In nasal diphtheria the nasopharynx may appear innocent with only moderate injection. Even close inspection of the nasal passages may fail to reveal typical diphtheria membrane. Only catarrhal rhinitis may present itself with suggestion of a foul odor.

The doctor must keep diphtheria in mind. If he fails to do so and uses penicillin locally or parenterally in the treatment of a mistaken case of diphtheria, it may inadequately inhibit the growth of corynebacterium diphtheriae or influence the other member of the mixed infection. Many patients with diphtheria have no significant complaints and these factors combined with the temporary improvement of the patient may lull the practitioner into thinking that satisfactory progress is being made until such complications as vasomotor collapse, paralysis and myocardial involvement suddenly face him.

The following death illustrates the tragedy of not making a correct diagnosis of diphtheria and of its confusion with other infections of the nasopharynx.

CASE ONE

A white, fairly well developed, 19 year old male was seen in the outpatient department of Middlesex General Hospital because of sore throat. A tonsillar abscess was present on the left with some membrane over the tonsil and uvula. Throat smears and culture reported numerous spirochetes but no diphtheria organism. After several days with no improvement relative to therapy prescribed he was admitted as an inpatient. He was now unable to swallow well. There was marked swelling of both tonsils, tonsillar pillars, peritonsillar region, uvula and soft palate. A necrotic ulcerative area was seen on the left tonsil. A large area of the soft palate was covered with whitish necrotic tissue. There were no other abnormal findings. His general condition was good.

He received penicillin parenterally 50,000 units every three hours; penicillin troches orally constantly; sulfadiazine 0.6 gram twice a day; and a liter of 5 per cent glucose in saline solution plus five grams of sulfadiazine intravenously once a day for three days.

Because of difficulty in swallowing, choking, breathing, and nasal regurgitation, tracheotomy was considered.

However the patient continued to improve. The cervical swelling lessened, temperature approached normal, the pharynx showed only slight evidence of inflammation. Mapharsen swabbing of the throat supplemented the treatment.

The blood count showed a hemoglobin 102 per cent; 5,230,000 red cells; 17,000 white cells; polymorphonuclear leucocytes 76 per cent; lymphocytes 22 per cent. Urine albumen was 3 plus and microscopic urinalysis revealed many leucocytes and occasional erythrocytes.

The patient continued doing well and was discharged on the ninth day with a diagnosis of Vincent's infection of the tonsils. But he was readmitted the next day complaining of weakness, inability to retain food, sleep or see well. The tonsils appeared hypertrophic but not acutely diseased and the oronasal mucous membranes were normal. There were no other abnormal findings. Two days later, his general weakness was more marked, he had a nasal voice and there was regurgitation of gastric contents through the nose. Hand grips were weak. The patient now showed paralysis of the soft palate and uvula, difficulty of phonation, and motor weakness of all peripheral muscles. A fortnight later, the temperature began to mount, the pulse was becoming rapid, there was a gallop rhythm and the patient was dyspneic. There was diminished resonance over the lower lobe of the left lung and he was coughing.

Urinalysis showed albumen 2 plus, sugar negative, acetone negative. Microscopic examination revealed many hyaline casts, a few coarsely granular casts, five white blood cells and an occasional erythrocyte. Hemoglobin was 93 per cent, red cells numbered 4,830,000, white count was 14,250, polymorphonuclear leucocytes 85 per cent and lymphocytes 14 per cent. The spinal fluid showed a cell count of 5, globulin negative, sugar 78, colloidal gold reaction 00000000. The plasma proteins were 7.55 per cent. The hematocrit was 48.5 per cent. The sedimentation rate was 25 mm./60 min./Westergren. Mazzini test was negative. The blood culture was negative.

The stool showed many ascaris lumbricoides ova and a few trichuris ova. Agglutination studies were negative for typhoid O and H, paratyphoid A, brucella abortis and proteus OX 19. An electrocardiogram revealed low voltage, an auricular and ventricular rate of 125, normal axis, and a PR interval of 0.27 second. The patient had been digitalized once with a full dose of 1.2 milligrams digitoxin and thereafter had received 0.2 milligrams a day, but it is unlikely that this dosage produced the markedly increased PR interval indicating partial heart block.

Therapy was general and supportive and consisted principally in the administration of vitamin B complex, vitamin C, oxygen, glucose and saline solution by vein. Towards the end, he was given penicillin parenterally when it was felt that he had a bronchopneumonia.

The patient said that he had never been immunized against diphtheria.

He died on the 27th day.

At autopsy, the pathologist found enlargement of the heart with hypertrophy and dilatation of both ventricles, congestion and aspiration bronchopneumonia of both lungs, some acute congestion and degeneration of the liver, acute congestion and softening of the spleen, ascaris in the intestines.

At microscopic study of the heart, there was evidence of a severe myocardial lesion in which necrosis and inflammation were lacking. The fibres were swollen with liquid and the surrounding interstitial tissue was very edematous. These findings of toxic degeneration of the myocardium were consistent with the diagnosis of diphtheritic myocarditis.

The following two cases illustrate the possibility of confusion between follicular tonsillitis and faucial diphtheria.

CASE TWO

Female, age 27, white, 3 months pregnant with a history of rheumatic heart disease and moderate hypertension, (160/105), weighing 151 pounds, well compensated and with no previous complaints, developed a sore throat with a temperature of 101 and generalized malaise. Examination revealed moderate reddening of the pharyngeal mucosa, bilateral injected tonsillar swelling with whitish non-confluent tiny patches of caseous material on both tonsils. There was no suggestion of a membrane. The lesions were typical of acute follicular tonsillitis. Therapy was started with sulfadiazine and sodium bicarbonate plus local irrigations. On the third day, the suggestion of a membrane covered both tonsils. A foul odor was noted with a diagnosis of acute follicular tonsillitis, the patient was given 300,000 penicillin units in beeswax and oil intramuscularly. Smears and cultures for diphtheria were taken which proved positive for the diphtheria organism, gamma streptococci and other gram positive cocci. The case represented one of mixed infection. The patient then received 60,000 units of diphtheria antitoxin and made an uneventful recovery. Subsequent information revealed that she had visited her young brother who had been ill for some time. He had been treated for "a persistent sore throat" (with penicillin) but had not responded, and it subsequently appeared that he had diphtheria. Neither patient had ever been immunized against diphtheria.

CASE THREE

A seven-year old boy had a sore throat, fever and general malaise. Temperature was 102. The pharyngeal mucosa was moderately injected, the tonsils were bilaterally enlarged, cryptic, and showed yellowish white non-confluent patches of necrotic caseous material, typical of follicular tonsillitis. A foul odor was noted. Smears and cultures proved positive for diphtheriae. He was given 30,000 units of diphtheria antitoxin and made an uneventful recovery.

The following case is one of nasal diphtheria.

CASE FOUR

An 18 year old male, was admitted to St. Peter's General Hospital with "an ordinary head cold" and some difficulty as to nasal breathing. He had been treated for three months for anemia, indolence and increasing sluggishness. Several days prior to admission small hemorrhagic spots appeared on the patient's body, particularly the lower extremities. Examination showed a young man somewhat asthenic, slightly dull mentally and lethargic. He was moderately ill, the temperature was 99 degrees, pulse 88, respirations 18. He had a nasal voice. Intranasal observation showed injected and congested hyperemic turbinates. The remainder of the nasal mucous membrane was likewise injected. No "suspicious" membrane was present but there was some crusting and suggestion of excoriation. He had significant seromucoid postnasal discharge. The pharynx was somewhat injected. A fetid odor emanated from the nose and mouth.

A small impetiginous lesion was present at the angle of the right side of the mouth. Small, hemorrhagic, ecchymotic spots were present over the legs. A diagnosis of nasal diphtheria was made and confirmed by the laboratory.

The patient was given 100,000 units of diphtheria antitoxin. In view of the work done by Kocher[2] relative to the treatment of the chronic diphtheria state, oral penicillin troches and a penicillin spray intranasally were also used. Consecutive nasal cultures became negative and the patient was discharged well two weeks after hospital admission. He had never been immunized against diphtheria.

COMMENT

When penicillin was first used in the treatment of gonorrhea and its specificity demonstrated, the drug won additional merited respect.

When it was proved that penicillin could produce a "cure" in most cases of primary and secondary syphilis, its "miracle effect" was overwhelming.

The medical profession soon realized the pitfall of this double edged sword. The recession and disappearance of an inconspicuous syphilitic chancre in a patient who had both gonorrhea and syphilis (when treated only for the former with penicillin) made it imperative to remember the possibility that a patient treated for gonorrhea might likewise also have syphilis.

A similar situation exists in the diagnosis and management of faucial diphtheria and the more common nasopharyngeal infections. The frequency of the use of penicillin in the treatment of the latter two with beneficial effect and the relative inhibiting influence of penicillin locally on *corynebacterium diphtheriae* make it imperative that the diagnosis of diphtheria be never overlooked. This is particularly true if a mixed infection is present. Early use of penicillin in the nasopharynx topically may so inhibit the activity of *corynebacterium diphtheriae* that subsequent smears and cultures may be negative although the toxin has been disseminated and absorbed. The only treatment for early acute diphtheria is adequate amounts of diphtheria antitoxin. Only too late, the physician may find that a patient supposedly treated for nasopharyngitis or tonsillitis and doing well, later develops complications of diphtheria.

CONCLUSIONS

1. Always keep diphtheria in mind in the presence of nasopharyngeal and tonsillar infection.

2. Never use penicillin in the nasopharynx unless you are certain of the diagnosis. If doubtful, take smears and cultures first. If still doubtful of diphtheria, give antitoxin.

3. Penicillin cannot replace diphtheria antitoxin in the treatment of acute diphtheria.

4. Penicillin when used properly in conjunction with the principles outlined by Kocher and Siemsen [2] is of definite value in the treatment of the chronic diphtheria carrier state.

5. The early use of diphtheria antitoxin is necessary to avoid complications.

177 Livingston Avenue

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

A number of changes in Board requirements and regulations are announced. New bulletins are available for distribution upon application and give details of all new regulations. These relate both to candidates, and to hospitals conducting residency services for training.

Foremost are the following:

(1) The ruling that applicants must receive adequate training in both obstetrics and gynecology has been defined as meaning a minimum of six-months, full-time, in the branch of either obstetrics or gynecology otherwise relegated to a minor role in a candidate's training and preference for practice.

(2) Acceptable preceptorship training is defined.

(3) The present regulation requiring at least six months of practice in the specialty following the completion of an acceptable training period, has now been extended, effective December 31, 1949, to a requirement of two years post-training practice limited to the specialty.

(4) Specific requirements for approval of hospital services for residency training are outlined.

(5) There is no further "temporary" approval of residency training. All hospitals holding any type of residency training approval will either be resurveyed or initially surveyed by the Council on Medical Education and Hospitals of the A.M.A. so that all future approvals, new or old, will be based entirely upon inspection following application. It is expected also that resurveys will result in withdrawal of present approval from institutions where standards are not being maintained.

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States and Canada on February 4, 1949. Application may be made until November 1, 1948. Application forms and bulletins are sent upon request made to:

American Board of Obstetrics and Gynecology,
1015 Highland Building,
Pittsburgh 6, Pennsylvania

ROENTGEN EVALUATION OF ABDOMINAL PATHOLOGY*

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Roentgenologic study of the abdominal lesions and their proper interpretation are major functions of the radiologist. The final opinion of the examiner in each case will depend on proper technical procedure, clinical acumen, power of observation, experience, ability to learn by his own mistakes, and finally, by proper analysis and rationalization of the case in question. The ability to obtain the greatest amount of information from the radiologic procedure is the secret of success. Abdominal lesions are so complicated, demonstrate so many variations that the correct solution of each problem requires an accumulation of all available data and personal experiences. The radiologist cannot accomplish this by himself. He must cooperate with the physician and surgeon and rationalize the case with them. By this method, he will be able to recognize better his own limitations and those of the x-ray procedure and point them out to his confreres. All of them will profit by surgical and pathologic findings whenever available.

The primary requisite of recognition of organic abdominal disease is its localization. The lesion may be confined to a single structure or may involve several organs at one time. It is therefore important to visualize each anatomic structure of the abdominal cavity. This has been accomplished by two chief x-ray procedures: (1) survey films and (2) use of contrast media. Structures which cannot be recognized by either method are studied by their anatomic relationship with those which already have been visualized e.g., pancreas and peritoneum. It is remarkable what progress in visualization of abdominal disease has been made since the discovery of the x-ray in 1895.

SURVEY FILMS

The survey study of the abdomen constitutes the most important phase of the examination. Radiographic survey study of the abdomen should be accompanied by fluoroscopic palpation of the abdomen and review of the thorax prior to the installation of any contrast material. This survey should precede any abdominal study for gastro-intestinal or urinary tract disease.

The survey films should be taken in two or three different positions and, if possible, one film should be upright. The most important findings according to etiology are:

1. *Congenital:* Situs inversus. All sorts of congenital abnormalities of the bony structures. Diaphragmatic hernia, eventration, congenital defect of the diaphragm.

2. *Traumatic:* Foreign bodies. Free air in the peritoneal cavity, following ruptured ulcers; subphrenic abscesses; fluid levels in the small bowel following perforation of the viscera after the gun shot wound; subcutaneous emphysema in the abdominal wall following ruptured viscus.

3. *Chronic degenerative pathology:* Enlarged spleen, liver (in blood dyscrasias), enlarged kidneys, calculi in the genito-urinary tract and gall bladder area, milk of calcium bile, biliary fistulae, calcifications in the liver, calcified hematoma, echinococcus cysts and spleen, calcified infarcts, thrombosis of the splenic vein, calcified mesenterial nodes; soft tissue masses in the pelvis or calcifications in the pelvic organs; fibroids, dermoids, fetal skeletal outline, vascular calcifications.

4. *Inflammatory lesions with or without obstructive symptoms:* Tuberculous or amoebic infections, mesenteric thrombosis, non-sclerosing ileitis, mesenterial lymphadenitis. In cases of regional ileitis with partial obstruction, one can note in the upright position, local accumulation of air and fluid in the right lower quadrant.

5. *Neoplastic:* Primary malignancy of the cardia of the stomach are recognizable by means of deformed gastric air bubble, abdominal masses, cysts, calcified neoplasms.

The survey study will not definitely identify each structure but it will guide the examiner so that he can better localize the lesion following the administration of contrast media. Often, survey films will force the examiner to change the sequence of the study; for instance, in a case of renal pathology with gastro-intestinal symptoms, one will follow up the survey study by contrast visualization of the urinary tract prior to gastro-intestinal studies. The survey study will enable the examiner to organize his examination better. Often, x-ray

* Read before the Section on Radiology, Annual Meeting of The Medical Society of New Jersey, April 28, 1948.

signs, not present upon the first examination, will be obvious upon re-examination a few hours or a few days later. Clinical radiographic follow-up of a case in question is mandatory whenever time permits.

STUDY BY CONTRAST MEDIA

Each structure of the abdomen has been visualized by certain opaque media. Some are used routinely, others in a particular case as indicated by history and clinical findings. The gastro-intestinal tract and the genito-urinary tract have been visualized in their entirety. Function of the organs may be observed fluoroscopically. The recognition of the pathology of the gall bladder was greatly enhanced by the Graham test. Liver and spleen are visualized by means of thorotrast. Its general use has been discontinued because of the danger of latent radio-activity and its permanent retention in the reticulo-endothelial system.[1] However, if used in definite malignancy, we can visualize metastatic liver pathology. Small amounts of the thorotrast are also used for visualization of the aorta and its branches in the abdominal cavity. Recently, 50 to 70 per cent diodrast [2] was substituted for the other opaque media and excellent radiographs of the abdominal vascular structures were obtained with rapid modern technics.

PERITONEUM

Both thorotrast and diodrast may be used for visualization of the peritoneum.[3] This phase of the study is still undeveloped but has great possibilities in the localization of disease, particularly of the retroperitoneal tumors. Other opaque media are used for visualization of the female organs, uterine cavity and tubes. Air and carbon dioxide can be used for the same purpose. Diagnostic pneumoperitoneum and tomography are occasionally used for localization of abdominal masses or adhesions or in suspected suprarenal lesions. All these procedures have their place in the proper "work-up" of a particular problem.

PANCREAS

No opaque medium, at the present time is available for the direct study of the pancreas. Any inflammatory or neoplastic lesion of this organ, of sufficient size, can be studied by analysis of the displacement of the adjacent organs. In this connection, one should emphasize the diagnostic value of the lateral and decubitus views of the upper lumbar spine in the study of the visualized upper gastro-intestinal tract. One should observe the distance of the superior and the descending portion of the duodenum from the spinal column, angulation or depression of the duodenum.[4] In many early pancreatic lesions or primary and metastatic retroperitoneal neoplasms, the relationship of these organs will change and lead to the proper diagnosis. Simultaneous visualization of the gall bladder together with the intravenous pyelogram is often of great diagnostic value in the localization of the abdominal disease. Retrograde and intravenous pyelography may occasionally be used to advantage.

SUMMARY

1. The accuracy of roentgen diagnosis of abdominal pathology depends on the clinical acumen of the radiologist and his team work with the physician and surgeon.

2. The personal experience of the radiologist, his ability to observe abnormalities and to rationalize each individual abdominal problem, is of prime importance.

3. To help the radiologist arrive at the proper analysis of an abdominal problem and to guide him, it has been my experience that survey films and fluoroscopy should be more widely used than at the present time. In this day and age, only the non-availability of x-rays can be considered an excuse for the omission of radiographic studies of each individual abdominal problem.

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31 Lincoln Park

OPERATIVE ASPECTS OF LOW BACK PAIN*

Henry Briggs, M.D., East Orange, N. J.

Sacro-iliac subluxation does not exist as an etiologic factor causing low back disability but only as a diagnosis causing confusion. This confusion is due to the fact that in a great many mechanical low back disorders there is pain referred to and tenderness over a sacro-iliac joint and its ligaments; and—if one looks carefully—a changed relationship can be observed between the sacrum and iliae. Pain and tenderness over the posterior sacro-iliac ligaments and a prominent posterior superior iliac spine are common findings. The changed relationship between the sacrum and iliae is due to muscle spasm. The pain and tenderness is of the referred type or due to an actual stretching of the sacro-iliac ligaments. The muscle spasm usually is due to an intervertebral disc disorder. Operative procedures should always be directed toward the discs, never toward the sacro-iliac joints.

Some low back disability may be due to disorder of the apophyseal joints. I have found at operation small loose bodies in a lumbo-sacral joint. I have many times observed a superior articular process digging into an inferior pedicle. What relationship these findings have to back pain and disability I do not know. There may be a "facet syndrome" but up to this time I have not made such a preoperative diagnosis. There are patients who complain of lumbo-sacral pain without radiation and who show essentially negative leg tests, yet who do have definite lumbo-sacral tenderness and are cured by lumbo-sacral fusions. There is no operative evidence in these cases of unstable fifth lumbar vertebrae and their discs look normal. These patients may have facet disturbances as the real cause of their back pain.

Myositis and myofascitis are terms usually applied to sore muscles spastic because of real pathology lying elsewhere. Occasionally, however, we find tender indurated nodules in muscle masses that seem to be the real cause of the painful back condition. I have removed two of such nodules, one in the back, one in the gluteal area. On pathologic examination, these did show inflammatory and fibrotic changes, and considerable relief was obtained in both cases from this minor operation.

Disorders of the intervertebral discs cause most of the pathologic conditions for which operations are performed today. Although I remember one typical disc picture in a boy about seven, I have never operated for a disc in anybody younger than the late teens. In teen-agers the disc contains no degenerated material, the annulus fibrosus is firm and the nucleus pulposus is resilient. Teen-agers injure a disc by lifting or in athletic activities. At operation the disc is found to be bulging posteriorly. It is difficult to tell whether this is a physiologic or a pathologic bulge. I have often found it necessary to inspect or palpate an adjoining disc before I could make an estimation. At times when an operation was completed, I had to wait for the end result before I knew whether my judgment was correct.

The disc bulge is not confined to one side although the pain is usually unilateral. The bulge appears about equal along the posterior border of the disc where the annulus is the thinnest but it also protrudes at least posteriolaterally into the foramen in a collapsing bellows like manner. I have found nerve impingement, assuming a fifth disc, on the first sacral root where the bulge had pushed the root backward against the fifth lamina and ligamentum flavum, and I have relieved this by cutting away the disc beneath the root. I have also found the intervertebral foraminal space diminished by the bulging disc. This constriction has been relieved by unroofing the foramen and removing some of the first sacral pedicle, by a foraminotomy. In one patient, there was a violent gluteal and thigh contraction on percussion of the apophyseal area—a positive tap test. Search showed a roomy foraminal space by palpation but the bulging disc had compressed the fifth root upward and

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superiorly against the pedicle of the fifth vertebra. This also was relieved by a foraminotomy but here part of the fifth pedicle was removed and the bulging disc shaved down. Remember these three pressure mechanisms when operating upon teen-agers for sciatic pain.

This same collapsing bellows bulging mechanism (and *not* the sacro-iliac joint) is without a doubt the cause of the backache and sciatica of pregnancy. Careful questioning reveals that with many female patients, their trouble originated in a pregnancy. I have been forced to operate only once in pregnancy. This patient had a disc that bulged but also had an actual disc rupture.

From the early twenties to old age, one finds the multiple manifestations of degeneration of the nucleus pulposus. The degenerated nucleus can rupture through the annulus fibrosus and the posterior longitudinal ligaments, and soft tissues and come to lie free in the spinal canal. This is not common. When the nuclear material is very soft, it may burst through the soft tissues, then flatten out beneath the dura and ooze along a nerve root making detection difficult. The first situation makes an operation for the typical backache and sciatica very easy. The second situation must be thought of when nothing obvious is seen when the spinal canal is exposed.

When the nucleus bursts through the annulus it usually is confined beneath the posterior longitudinal ligaments and soft tissue and these have to be incised before the mass can be removed. The situation of this mass varies greatly. For the purpose of description I will assume a fifth lumbar disc herniation. It usually lies beneath the first sacral root. The only difficulty that I have encountered in this location is when the mass is very large and the root is so taut over it that it cannot be retracted easily. A few times I have got at the mass by going down between the root and the dura but usually by going wide, even to taking out considerable first sacral pedicle, one can come at it from the side without damaging the first sacral root further by rough retraction.

Even a large midline disc can be missed readily it not purposely looked for. A nucleus may rupture at the head side or tail side of the disc. If it pushes out head side in the midline, it will lie well up under the fifth lumbar laminae and be very easy to miss. Palpation by a flat instrument on the dura in the midline will locate such a disc or midline laminectomy and finger palpation or by going under the dura with a probe bent at right angles.

The protrusion that probably is most often missed (but never should be) is the small one that lies lateral under the overhang of the facet. Instrument palpation can be deceptive. The first thing I do in exploring a disc is to take off this facet overhang, and I do it at both the fifth and the fourth levels in an effort to locate pathology. When I locate a ruptured disc, I generally remove this overhang to facilitate exposure.

The hardest ruptured disc to deal with is the one located in the foramen. I have found them lying at the very lateral aspect of the canal where the disc swings to the lateral aspect of the vertebral body. I used to run a catheter on wire out the foramen feeling that this maneuver would be diagnostic of foraminal constriction. When it was discovered that the nerve could be squeezed by a disc, still leaving plenty of room in the canal as a whole, this procedure was abandoned. I now employ vigorous tapping on the articular processes as the first step. Then I palpate with a bent probe along the disc. To do this in a satisfactory manner the overhang of the facet usually has to be removed and very often the anterior aspect of the inferior articular process by what I call an "undermining foraminotomy". If I am still not satisfied, I go right out through the articular process taking out the facet.

A disc can be protruding at one time and not protruding at operation. This is, unfortunately, very common. There are two mechanisms involved. A herniated nucleus can slip back between the vertebra at operation, leaving a tiny wisp of nuclear material outside the disc as evidence. This is not the usual situation. The common mechanism is a localized bulging, sucked flat by the positioning of the patient on the operating room table. In these cases the annulus is very thin and the nuclear

material very soft. A sense of "feel" helps tell the surgeon when the disc is pathologically soft but I find that I usually have to expose the disc adequately, scraping it clear, looking at it, feeling it, before I can be sure it is one of these truly concealed types of disc. In older people all the discs may be soft or bulging; and again it may be very hard to tell which disc is the offending one except by the appearance of root thickening and adhesions.

In teen-agers a disc bulges probably because the nuclear material penetrates the body of an adjacent vertebra. In older people, the simple softening of the nucleus and of the annulus allows compression of the disc space and the bellows-like bulging to occur very commonly. In the degenerated annulus, hypertrophic spurring develops almost to a complete bridging of the vertebra at times. With this there is thickening of the ligamentum flavum. To the degenerative changes much low back pain and sciatica can be attributed.

Proper surgery in these cases affords outstanding relief even though there is no ruptured disc to excise. Root pressure may be at three sites. There can be rarely a marked midline spurring tending to block the canal which can be handled only by midline laminectomy. There frequently is pressure, assuming a lumbo-sacral disc on the first sacral root when it becomes compressed between the hypertrophic spurring and the ligamentum flavum. Removal of the ligamentum flavum and part of the fifth lamina usually relieves this condition. Occasionally there is a large localized spurring which I have tackled with a gouge. The most common site of pressure is in the foramen. The collapsing and bulging disc diminishes this space. There frequently is lipping about the facet which also encroaches upon the space. Tapping and instrument exploration will reveal this constriction.

Wide foraminotomy with exploration of the root is the necessary procedure. I have performed bilateral foraminotomies, both at the fourth and fifth levels. When x-rays show a collapse of the intervertebral space I make a foraminotomy, undermining or complete, almost routine. I feel sure that there is going to be more and more surgery directed toward the foramina and there is a very large surgical field to be developed in the so-called hypertrophic arthritis spine.

In spite of the knowledge I have gained in the last few years, I still find the low back a difficult problem. My concepts change. For a long time I explained symptoms by assuming that there was almost always an impingement or impending inpingement of a nerve root and I have sought diligently for such mechanism as you can see. I still operate many times, however, and find no evidence of root oppression. I now wonder, for example, whether a rupture of a nucleus into a vertebral body or an anterior lateral bulge would not give a list of the trunk and secondary sciatica say from pyriformis spasm. To help clarify the situation I am now doing pantopaque studies using considerable quantity of that material. Pantopaque or any other contrasting material will not solve the problem. It will always rest, particularly the fifth lumbar foraminal situation, in the judgment and skill of the orthopaedic surgeon.

144 Harrison Street

CLINICAL CONFERENCE

The date for the 1948 Clinical Conference of The Medical Society of New Jersey has been changed from December 1 to December 8. This change has been made necessary to avoid conflict with the interim session of the American Medical Association which will run until December 3 this year.

The Clinical Conference of The Medical Society of New Jersey will therefore be held in Trenton on Wednesday, December 8, 1948.

The program and further details will be announced in subsequent issues of this JOURNAL.

STATE ACTIVITIES

MEDICAL-SURGICAL PLAN OF NEW JERSEY

SUPPLEMENTARY REPORT TO THE HOUSE OF DELEGATES

To insure complete understanding within the profession, with respect to the Supplementary Report of Medical-Surgical Plan to the House of Delegates, may we point out:

1. The House of Delegates approved the Plan's request for authority to issue a new subscription contract which would provide that participating physicians deem as payment in full the amount payable by the Plan for eligible services rendered in cases where the subscriber's annual income does not exceed $5000, and in which the subscription rate and amount payable to physicians are adjusted to incomes up to $5000.

2. This action of the House of Delegates is permissive in character. It remains with the Board of Trustees of the Plan to determine when and how soon the proposal can be made effective and to develop such a contract.

3. The new contract rate, the new salary limitation and the new schedule of benefits are interrelated. After action by the Board of Trustees of the Plan these must be submitted to the Department of Banking and Insurance of the State of New Jersey for its concurrence. Then the new contract must be prepared and printed. About six months' time is necessary to place any such program in effect.

4. If and when the new contract is made effective, due notice will appear in the JOURNAL. In the meantime, the current contract of the Plan, with the current salary limitations, and the current schedule of benefits, remain effective.

NEW JERSEY HEART ASSOCIATION ORGANIZED

An organizational meeting of the trustees of the New Jersey Heart Association was held on June 30. The meeting was called by W. Paul Stillman, chairman of the board, for the purpose of discussing plans for the proper expansion and development of the Association.

The New Jersey Heart Association was incorporated May 8, 1948, with Governor Driscoll as Honorary Chairman of the board.

The officers were authorized to submit the Association's incorporation papers for the purpose of affiliating with the American Heart Association. The American Heart Association has approved the request for affiliation.

The immediate necessities of the New Jersey Heart Association are, first, funds to establish and maintain a central office and a secretary. Second, the developing of a widespread and representative membership throughout the state.

The objectives encompass three programs of activities. (1) An educational program which will be bilateral in its approach, including a multipronged educational program directed at the lay public and a scientific program including regularly scheduled meetings and periodic scientific releases for physicians; (2) a medical care program to include establishment of cardiac clinics and the implementing of existing facilities for examination, diagnosis and therapy; (3) a program for scientific research.

The objectives of the New Jersey Heart Association as set forth in its charter are:

1. The study, dissemination and application of knowledge concerning diseases of the heart and the circulatory system.

2. The improvement of facilities and services for the diagnosis and treatment of such diseases.

3. To encourage the advancement of specialized knowledge among physicians, nurses, medical social workers, teachers and public health authorities, of diseases of the heart and the circulatory system so that each of these groups may be more peculiarly fitted to undertake the problems incident to the development of community programs designed to combat the effects and eliminate the causes of diseases of the heart and the circulatory system.

4. To foster a program of lay education designed to instruct the public as to the nature and effect of diseases of the heart and the circulatory system and to bring to the attention of the public the advisability of regular medical examinations for the prevention or the arresting of such conditions.

5. To disseminate information concerning the symptoms, treatment and prevention of diseases of the heart and the circulatory system.

6. To engage in any other activities which contribute to the control of diseases of the heart and the circulatory system.

7. To associate itself, by affiliation or otherwise, with the American Heart Association, Inc.

8. To conduct, from time to time, public relations and fund-raising campaigns designed to publicize and support the program of this Association and to provide funds to be distributed on a local or a national basis for treatment of, or research in, cardiovascular disease.

BROOKINGS INSTITUTION'S CONCLUSIONS ON MEDICAL SERVICE IN THE U. S.

In May 1947, at the request of Senator H. Alexander Smith of New Jersey, Chairman of the Subcommittee on Health of the U. S. Senate, the Brookings Institution undertook the preparation, entirely at its own expense, of a memorandum on "Medical Care for the Individual". In February 1948, an outline of the study and the "Conclusions" were released. These are the findings of experienced analysts and carry the stamp of the Brookings Institution, one of the most reliable institutions in the field of social, economic and governmental research.

The conclusions of this study lend impressive support to the principal contentions of those who have consistently opposed efforts to enact national compulsory sickness insurance in the United States. The report is clearly of major, if not decisive, importance. It is an even more exhaustive repudiation of compulsory sickness insurance than was contained in the final report of the "Committee on Medicine and the Changing Order" of the New York Academy of Medicine, published in 1947.

Here are the conclusions:

1. Probably no great nation in the world has among its white population better health than prevails in the United States.

2. It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. These trends will continue unabated under our present system of medical care.

3. The nonwhites in the United States have poorer health than the whites, but this condition is not primarily or even mainly due to inadequacy of medical care.

4. The advances in health among both the whites and nonwhites that have been made in the United States in the past four decades do not suggest basic defects in the American system.

5. The draft statistics have been widely used to show bad health among the American people and the need for revolutionary changes in medical care of individuals. They are unreliable as a measure of the health of the nation and cannot be used to show the extent of the medical needs of the country as a whole.

6. Present medical care in the United States compares favorably with that which existed in other leading nations prior to the second World War.

7. Conditions in poor rural areas that lack the resources to support adequate public services cannot be satisfactorily solved by subsidies.

8. The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to maintain an insured status. Most American families do have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure.

9. Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. Past experience with government regulations and control in the United States causes doubt as to whether it encourages initiative and development.

10. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system.

11. Compulsory insurance would inject the government into the relationship between practitioner and patient. A real danger exists that Government actions would impair that relationship and hence the quality of medical care.

12. The administration of compulsory insurance would require thousands of government employees for accounting, auditing and inspection and investigation.

13. The cost of medical care presumably would increase because of (a) administrative expenses; (b) the tendency of insured persons to make unnecessary and often unreasonable demands upon the medical care services; and (c) the tendency of some practitioners and agencies to exploit the system for their own advantage.

14. The adoption of compulsory insurance would not immediately make available adequate service for all, because there are not at present the facilities nor a sufficient number of trained and experienced physicians, dentists and nurses to meet the demand which would result from compulsory insurance.

15. It seems questionable whether a country which once embarks on compulsory insurance can turn back; more likely it will attempt to remedy defects by more complete government control and administration.

In its recommendations to Senator Smith's subcommittee, the Brookings Institution urged (1) that the national government "leave to the individual states the question of whether compulsory health insurance is to be adopted or whether the provision of professional services is to be left in the realm of free enterprise. It seems highly probable that in many communities the intelligent cooperation of consumers and practitioners will develop satisfactory arrangements that remain subject to their own control without national government ad-

ministration. It seems highly improbable that this experimentation—possible under our federal form of government—will ultimately develop a single pattern that is applicable to all sections of the country and is desired by a large majority of the people;" (2) that "For the time being the national government and many of the state governments may well devote their resources and energies to:

a. Research and development in the fields of public health.

b. Health education at the school level.

c. Teaching preventive medicine.

d. Assisting the acquisition of physical facilities and training of personnel.

e. Providing systematic care for the indigent and the medically indigent."

(3) that "From the standpoint of public relations, governments might be well advised to leave adult educational campaigns for the control and prevention of disease to the national, state, and local voluntary organizations, which have been able to enlist the active cooperation of leading laymen in most sections of the country. It must be remembered that good health is not exclusively a matter of medical care; it also impinges upon causative factors that are nonmedical, such as food, shelter, vice and crime, transportation, and industry. Its maintenance depends also upon the intelligence, interest, and cooperation of individuals, families, and local communities."

The report reminds us that these recommendations are "not widely at variance" with those contained in the Majority Report of the Committee on the Cost of Medical Care (1932). It is pointed out that the years since 1932 have witnessed a "great growth" in voluntary insurance both for hospitalization and for medical services; state experimentation with cash sickness insurance (Rhode Island, California, and now, New Jersey); a "growing willingness" on the part of physicians to cooperate in the development of plans for prepayment of medical care; and "a profound change" in the earnings of the American people which "greatly reduces the number who cannot afford adequate medical care if they desire to purchase it."

The report concludes with the observation that "It would seem unwise at this time to substitute for these developments a system of compulsory health insurance by national law which would have the unfortunate tendency to freeze policies and eventually retard medical progress."

The study is published in the form of a monograph. Copies of the monograph entitled "The Issue of Compulsory Health Insurance" can be secured by sending remittance to Brookings Institution, 722 Jackson Place, N. W., Washington 6, D. C. (The price — paper bound, $2; cloth bound, $4.)

JAMES E. BRYAN,
Executive Officer.

HONORARY DEGREE TO DR. NORTON

Dr. James F. Norton, President-Elect of The Medical Society of New Jersey was awarded the degree of Doctor of Letters *honoris causa* by St. Peter's College on June 14. The citation stated that the award was "in recognition of Dr. Norton's exemplary service to the community of Jersey City and to the state of New Jersey, both as a leader in medical progress and as a leader in Catholic Action". Dr. Norton is a graduate of St. Peter's—class of 1914.

ADVANCE ORDERS FOR TRISTATE DIRECTORY

Now is the time to put in your advance order for the 1949 edition of the Medical Directory of New York, New Jersey and Connecticut. This valuable volume names every practitioner in the three states, gives his medical school, specialty and hospital connections, and lists every hospital in the area with full staff rosters. The cost of this compendium is fifteen dollars. Because of the paper shortage, only enough copies will be printed to meet the demand. While it will not be ready for distribution until January 1949, you must order it this summer if you want to be sure of getting your copy. Send the check for $15 and your order to Mr. Dwight Anderson, Medical Society of New York, at 292 Madison Avenue, New York 17, N. Y.

WITH NEW JERSEY MEDICAL AUTHORS

Compiled by HAROLD M. GOETTEL, Librarian
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ONE HUNDRED YEARS OF THE TRENTON STATE HOSPITAL

A HISTORICAL NOTE

By EMIL FRANKEL, Ph.D., Department of Institutions and Agencies, Trenton

The Trenton State Hospital for the mentally ill opened on May 15, 1948, was thus described in the earliest annual report: "Reposing in the midst of the most beautiful scenery in the valley of the Delaware, combining all the influences which human art and skill can command to bless, soothe, and restore the wandering intellects that are gathered in its bosom, the state may proudly point to this asylum, as a noble illustration of that charity, which, born from above, diffuses itself in blessings on the poor and unfortunate."

Serious thought was given by the first staff, to an analysis of the causes of insanity. "It appears that the causes of insanity are often obscure, and, when traced, are found to be as various as the physical causes that disturb the health, or the moral topics that affect communities, families and individuals".

It was further observed that many persons inherit a predisposition, or constitutional tendency to this disease. "The occurrence of ill health in persons thus predisposed, and especially if operating in connection with any disturbing moral cause, as the death of kindred, pecuniary losses or disappointments, unusual religious anxiety or excitement, etc., is very likely to produce it."

A section of the first report concerns itself with a forward-looking program of the "Treatment of Insanity". "In determining the treatment, reference is necessary to all the causes known to have had an influence in the development or progress of the case, whether nearly or remotely connected with it. With this view, his previous social, civil and domestic relations and pursuits, should be understood and considered."

It was felt that "the different classes of organs and functions should be carefully examined, to ascertain whether, and how far, his disease is connected with physical, mental or moral causes, either separately or combined".

Having ascertained "what are the true indications for treatment, it was divided into medical and moral", the report explains that "the former includes the use of general and local depletion, medicine, baths, regulations of diet, etc.; the latter, all those means and influences brought to bear upon the person in his new situation, as association with others, employment, amusements, regular habits of rising and retiring, of order and cleanliness, attendance on religious services, etc."

The first medical director Dr. H. A. Buttolph felt "that there can be no doubt that with due attention to classification the insane derive important advantage from association in asylums"; and he points out the great importance "that appropriate curative treatment be resorted to early after the attack. The statistical records show that a much greater percentage of recoveries occur of the persons treated within the first few months of the attack, or during the first year of the disease, than of those in whom it has existed for a longer period."

In line with the thought that "the mental symptoms of this disorder are now universally regarded as arising from an excited, depressed, or disordered state of the brain" it was considered imperative "to preserve this member in a healthy state, by equalizing the action of its various parts, and by promoting a healthy relation between it and the organs of the body, is to use the most effectual means for maintaining the ascendency of reason, or for restoring it when lost".

The report ends up by pointing out: "Let the education of the young be conducted with special reference to the equal and harmonious development of all the faculties and feelings, and the disturbing moral causes to which they are afterwards subjected, will be deprived of much of their baneful influence: the minds of men, thus prepared, will be invigorated and improved, rather than overwhelmed and shattered, by the adversities of life".

COURSE IN TRAUMATIC SURGERY

The well known, intensive, one-week course in *The Treatment of Fractures and Other Traumatic Conditions* will be given as usual in Boston. This year the course opens on September 20 and closes on September 29. It is under the auspices of the Harvard Medical School. For details write to Graduate School, Harvard Medical School, 25 Shattuck Street, Boston, Massachusetts.

"PUBLIC RELATIONS IS PUBLIC SERVICE"

The theme of the first annual conference of public relations chairmen and officers of the county and state medical societies in New Jersey (held June 13, at the State Society's headquarters in Trenton) was: *Public Relations is Public Service.* Purpose of this meeting was threefold: to inform the county societies of the public relations work of the State Society; to outline a program of public service for county societies, coordinated with the State Society work; and to explore methods whereby the work of the county societies may be aided by the State Society. Dr. William E. Bray of Pemberton, Chairman of the Subcommittee on Public Relations of The Medical Society of New Jersey, presided.

In opening the conference, Dr. Bray pointed out that any program of public service initiated by the State Society will be only as effective as the county societies make it, for it is the county societies and the individual physicians who are in touch with the public. Dr. Bray urged each county society to equip itself with an active, well organized public relations committee, as has already been recommended by the House of Delegates of The Medical Society of New Jersey.

The present educational services of the State Society were described by Mr. Bryan, Executive Officer of the State Society. These comprise a weekly health education column known as *Health Hints,* distributed to some 230 daily and weekly newspapers and to some eighty industrial house organs throughout the state; a weekly *Junior Health Hints* service distributed to 1,600 school teachers and health educators who have requested this material for classroom use; a *Quarterly News Letter* to some 250 cooperating agencies interested in medicine, health, or welfare; weekly health broadcasts through ten major radio outlets in New Jersey, using material furnished by the American Medical Association; and a monthly *News Letter* service directed to members of The Medical Society.

Mr. Bryan also described existing contacts and relationships between The Medical Society of New Jersey and the members of the Society; other medical organizations; allied professional groups; voluntary health agencies; governmental agencies; civic leaders; editors; and the Woman's Auxiliary. He mentioned various formal mechanisms, such as the New Jersey Health Congress and the New Jersey Council of Professions through which these contacts have been extended and developed.

The Public Relations Committee introduced an attractively prepared compendium of official policies and objectives of The Medical Society of New Jersey, comprising a nine-point public service program for county medical societies. The plan calls for extension of health education services through newspapers, schools, and by radio; local plans to assure 'round-the-clock emergency service for patients needing medical attention; cancer education for physicians and the public; medical leadership to bring about better local health department services; plans for medical care for indigent and medically indigent patients; medical care for old age assistance clients; a plan of medical care for dependent children and families; suggestions for a membership campaign by the county medical societies.

Purpose of the compendium is to set forth a few of the Society's official policies together with practical suggestions for the county medical societies looking toward actual realization of these programs in the local communities throughout the state.

The Society's programs for medical care of needy persons, including old age assistance clients, dependent children and families and general relief clients, were discussed by Dr. Norman Scott, Director of Medical Care Distribution.

With reference to these plans for medical care of special groups and to the State Society's program of voluntary health insurance through the Medical-Surgical Plan of New Jersey, Dr. Scott stressed that all these programs are related to the underlying purpose of The Medical Society of New Jersey; namely, to see to it that medical care is available to every citizen if, as, and when needed, and at fees within his capacity to pay; or, if he is a public charge, at costs which the public should be reasonably expected to pay. "If we don't make medical care available to everybody," Dr. Scott warned, "we are going to have federal control of medicine". Pointing out that Labor still wants a federal program, no matter what is done for people on a voluntary basis, Dr. Scott said this makes it all the more imperative that the medical profession demonstrate its concern and sincerity in order to maintain its status as an independent professional group. "The modern physician," he said, "must return to the philosophy of service for which our forebears in the profession were so distinguished".

Dr. Scott mentioned the ten principles governing the cooperation of the medical profession and the

allied and official agencies which had been adopted by the House of Delegates and aproved in essence by the American Medical Association. He also described briefly the proposed changes in the Medical-Surgical Plan which were approved by the House of Delegates of The Medical Society of New Jersey at its last meeting. He pointed out that the transition from the old to the new policy requires a great deal of negotiation and takes considerable time.

Mr. Bryan discussed the purpose and use of the "Compendium" of policies and objectives submitted to this conference. He emphasized that the nine programs recommended to the county societies in this compendium do not comprise all of the current major public service projects of the State Society. For example, the compendium contains no reference to the school health improvement program, since organization work in this program has been referred to the Woman's Auxiliary and is already substantially completed by them. In this connection, Mr. Bryan suggested that the county societies take a more active interest in promotion of the objectives of the school health program. There is, he said, a tendency for the medical societies to assume that the entire program is being adequately handled by the Woman's Auxiliary, whereas their function is only to lay the ground work of organization of the county school health councils. The basic objectives of the program—the "Four Points"—are official policy of The Medical Society. Hence, the leadership of both the county and state societies is still needed in stimulating the implementation of these four points and in counseling on their medical aspects.

A second point of major interest to The Medical Society omitted from this compendium is the extension of voluntary medical care insurance through the Medical-Surgical Plan of New Jersey. This was omitted, Mr. Bryan explained, because the plan is in process of revision. Still another major concern of the Society is the control of heart diseases, and this was omitted because plans for organization of a New Jersey Heart Association are still in the embryonic stage. Other programs omitted for various reasons from the current compendium, Mr. Bryan pointed out, are tuberculosis case finding, the formation of local health councils, and the organization of county society committees for emergency medical defense.

These and other programs, Mr. Bryan said, when complete will doubtless comprise material for another nine or ten point compendium of official objectives and purposes to be submitted to the county societies.

Memoranda on four of the points listed in the compendium have already been sent out separately to the presidents and secretaries of each of the county societies with specific recommendations for action on the part of the county society. These four memoranda relate to the cancer program, local plans for assuring medical care in emergencies, action to increase the use of "Health Hints"—the Society's weekly educational service through the newspapers, and county plans for care of old age assistance clients.

It was agreed that the chairman of each county society public relations committee should henceforth receive a copy of all memoranda on programs or policies sent out by the State Society to the presidents and secretaries of the county societies.

Dr. L. S. Snegireff, Medical Director of the American Cancer Society, New Jersey Division, spoke on the cancer educational program formulated by the Society's Advisory Committee on Cancer Control. The Committee proposes that each county society or group of neighboring societies hold one scientific program on cancer each year, and also arrange at least one public meeting on cancer in cooperation with local chapters of the American Cancer Society. Funds for honoraria and expenses of highly qualified professional speakers for the scientific programs will be furnished by the New Jersey Division of the American Cancer Society. Dr. Snegireff recommended that wherever possible, nearby speakers be obtained. He emphasized also that in public discussions of the cancer problem, the place of the individual physician in the cancer control plan and the philosophy and achievements of the New Jersey program should be stressed.

Dr. Bray discussed the development of speakers bureau services, announcing that in the next few months a subcommittee of the State Society's Public Relations Committee will make a survey of the speakers bureaus already operated by several of the county medical societies. The chairman of the Survey Committee is Dr. Harrold A. Murray of Essex County.

Dr. Bray said that one of the principal questions to be considered is whether The Medical Society should solicit opportunities to present speakers before lay groups or should merely await invitation to send speakers. Dr. Murray expressed the opinion that if the speakers bureau operates efficiently and if properly qualified speakers are provided, solicitation of such opportunities will not be necessary for long.

Contingent on the results of the state survey, Dr. Bray said, the state committee hopes to develop a plan for a coordinated county and state society speakers bureau.

Discussing the topic "County Society Leadership in Community Health Planning", Dr. Harrold A. Murray said that in Essex County, the medical society has invited all local health organizations to attend county society meet-

ings and to take part in promoting county society programs of public education. "We go to them," Dr. Murray said, "carrying the message of organized medicine and our desire to cooperate with them". In his year as president of the Essex County Medical Society, Dr. Murray estimated he had attended nearly sixty meetings of outside groups and he expressed the opinion that these groups appreciate this evidence of the Medical Society's interest in their affairs. Public relations, said Dr. Murray, is a question of "whom do you know—how do you meet them—and how well do you sell them your purposes and your point of view?"

The speakers bureau in Essex County, Dr. Murray pointed out, has avoided taking part in controversial discussions of socialized medicine but has concentrated on furnishing speakers on health and medical subjects.

Discussing the program for organization of county and part-county health departments, Mr. Bryan emphasized the need for medical society leadership in informing the public of the certain advantages of such health department reorganization and in stimulating public support for the enactment of necessary legislation.

The functions and activities of the Woman's Auxiliary in the public relations of organized medicine were discussed briefly by Dr. William E. Dodd, Chairman of the Advisory Committee of The Medical Society of New Jersey to the Woman's Auxiliary. Dr. Dodd traced the history of the Auxiliary and the development of its present scope of activities. He described the achievements of the Auxliary in setting up general meetings for public education and in helping with the implementation of such programs as the better school health plan. He emphasized that the Auxiliary's responsibility is limited to the organization of local school health councils. The Auxiliary, he said, should not be credited for the good or blamed for the shortcomings of the program itself. Dr. Dodd expressed the belief that the Auxiliary can be of the greatest help to The Medical Society in its public relations work in helping to achieve specific objectives, especially where they involve public support and participation.

Others who spoke briefly were: Mr. Fred Miebach, Public Relations Director, and Mr. Thomas Walsh, Field Representative of the New York State Medical Society; Dr. J. Howard Hornberger, President, and Dr. L. Samuel Sica, Chairman of the Board of Trustees of The Medical Society of New Jersey. Representatives of twelve counties were present, comprising a total of thirty persons. The county societies represented were: Bergen, Burlington, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Passaic, Union and Warren.

CORRECTION

Due to an error in the author's manuscript, the word *vasoconstriction* in the seventh line of page 237 of the May 1948 issue, was used instead of *vasodilatation* in the article on Nasal Congestion by Dr. W. G. Talmadge. Readers are requested to make this correction in their copies. Delete the word "vasoconstriction" and insert the word "vasodilatation".

COURSE IN NEUROPSYCHIATRY

Announcement is made of an intensive and practical course in neuropsychiatry to be given in Newark on Monday and Thursday evenings, beginning September 9, 1948, and running for fifteen weeks thereafter. The course is acceptable for the enrollment of physician-veterans under the "G.I. Bill of Rights". Tuition fee to nonveterans is $125. Rutgers University is administering the course, in cooperation with the New Jersey Neuropsychiatric Association. The sponsoring agencies describe the course as "fashioned to meet the needs of the physician who wants training in neurology and psychiatry, of the candidate for American Board examinations, and of the practitioner who desires simply to sharpen his skills in the specialty".

The course includes work in neuro-anatomy, neuro-pathology, psychopathology, neuro-roentgenology, psychodynamics, clinical neurology, clinical psychiatry, neuro-physiology, psychosomatics, electro-encephalography, psychotherapy, child psychiatry, group therapy, forensic psychiatry, mental hygiene, and related topics. Classes meet from 7 to 10 p. m. every Monday and Thursday evening throughout the fall, representing an aggregate of ninety hours of intensive work.

For program and application blank, write to: New Jersey Neuropsychiatric Association, 82 Clinton Avenue, Newark 5, N. J.

SUPPLEMENTARY LIST No. 4

TO THE

1948 OFFICIAL LIST OF MEMBERS

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Abrams, Benjamin P., 803 Garden st., Hoboken (9)
Adler, Joseph, 933 Avenue C, Bayonne (9)
Ambrose, Frederick H., 304 E. High st., B. Brook(18)
Beim, Norbert, 660 Broadway, Paterson (16)
Bergsma, Daniel, N.J.S.D. of H., State H., Trent'n(11)
Brophy, Francis X., 55 Gifford av., Jersey City (9)
Catanzaro, Vincent J., 316 Midland av., Garfield (2)
Costa, Philip L., 88 E. Front st., Red Bank (13)
Davis, J. Stannard, 55 Kings Hwy. E., Haddonf'd (4)
Deignan, William L., 257 Dodd st., East Orange (7)
Doyle, John J., 426 Fairmount av., Jersey City (9)
Fessler, William, 31 Knox av., Grantwood (2)
Fioretti, Ralph J., 315 Rochelle ave., Rochelle P. (2)
Firtel, Saul I., 1060 Broad st., Newark (7)
Flax, Jacob L., 31 Lincoln Park, Newark (7)
Freyberger, George A., 85 Columbia ter.,Weeh'k'n(9)
Giannotto, Anthony S., 403 South 10th st., New'k(7)
Glazer, Edward, 84 Richmond av., Deal (13)
Irmish, George W., 375 W. State st., Trenton (11)
James, J. Thomas, 45 Vandeventer av., Princet'n(11)
Kanning, Frederick R., W. Allendale av.,Allend'le(2)
Klein, Alfred, 1 Rue de la Marne, Rabat, Africa (9)
Loeb, William A., Vet. Administration, Lyons (18)
Mackowsky, Edwin L., 241 Second st., Jer. City (9)
Mango, Concetta G., 1 - 78th st., North Bergen (9)
Matera, Joseph, 506 Garden st., Hoboken (9)
McGuire, Joseph T., 54 Main st., Lodi (2)
McKinney, Thomas S., 20 Grand av., Ridgef'd P. (2)
Mockett, Walter W., 55 E. Magnolia av.,Maywood(2)
Muller, Joseph H., 867 S. 13th st., Newark (7)
Neary, Edward R., 210 Carlton ter., Teaneck (2)
Nelson, Clifford H., 200 Isabella av., Irvington (7)
Neville, Robert J., 547 Main st., Hackensack (2)
Parker, James W., 175 Shrewsbury av., Red B'k(13)
Richardson, Arthur Hays, 60 Orange rd., M'tcl'r (7)
Rooks, Wendall, Wyckoff (2)
Roth, Samuel R., 31 Lincoln Park, Newark (7)
Rowe, Joseph A., 174 S. Maple av., Ridgewood (2)
Scheip, James R., 343 S. Pleasant av., Ridgew'd (2)
Schiro, S. Robert, 73 Main st., Lodi (2)
Selikoff, Irving J., 707 Broadway, Paterson (16)
Sharlin, Herbert S., 301 Union st., Hackensack (2)
Sivolella, Nicholas A., 245 Clifton av., Newark (7)
Smith, Bryan A., 10 N. Monroe st., Ridgewood (2)
Spitaleri, Liborio N., 343 Union st., Lodi (2)
Sporer, Andrew, 707 Broadway, Paterson (16)
Stassi, Anthony, 481 Passaic av., Lodi (2)
Strahan, Frank G., 473 Broadway, L. Branch (13)
Street, Daniel B., 27 Woodlawn av., Jersey City (9)
Sullivan, James A., 19 Kensington av., Jer. City (9)
Zacchino, Arnold, 1001 Anderson av., Palisade (2)

ASSOCIATES

Cacchioli, Louis G., 26 Dover st., Newark (7)
Rocco, John D., 729 Summer av., Newark (7)
Weinberg, C. Richard, 597 Clinton av., Newark (7)

OBITUARIES

DR. WALLACE PYLE

Dr. Wallace Pyle, eye, ear, nose and throat specialist who had practiced in Jersey City for fifty years, died at his home in Orange on June 11, 1948, after a long illness.

Born in Jersey City in 1876, Dr. Pyle attended the University of Wisconsin and was graduated from the University of Pennsylvania Medical School in 1897. He was founder of the Fairmount Sanitarium in Jersey City, which is no longer in operation, a member of the board of Christ Hospital for 45 years and had been associated with Jersey City Medical Center, Bayonne Hospital and St. Francis Hospital in Hoboken.

For many years Dr. Pyle specialized in cataract and mastoid operations and was one of the early members of the American College of Surgeons. He was an honorary and emeritus member of the Hudson County Medical Society.

DR. WILLIAM ZIMMER

Dr. William Zimmer of Hillside, died in Newark Beth Israel Hospital on June 9, 1948. Death was attributed to a heart attack.

Dr. Zimmer was born in Newark in 1907 and was graduated from Columbia Medical School in 1931. He served his internship in Jersey City Medical Center from 1932 to 1934, and then practiced medicine in Hillside and Newark. He entered the Army Medical Corps in 1942 and served in various army hospitals in this country during the war. At the time of his death he was on the staffs of Elizabeth General Hospital, Community Hospital, Presbyterian Hospital and the Beth Israel Hospital in Newark. Dr. Zimmer was well known for his activities in civic and veterans affairs.

THE BULLETIN BOARD

Red Cross Blood Banks

One of the liveliest, stormiest, and most significant meetings of the many attended by your Executive Officer during the course of the recent A.M.A. Meeting in Chicago, was an open session of the Reference Committee of the House of Delegates on Miscellaneous Business. This meeting was devoted principally to consideration of resolutions which would have caused the A.M.A. to withdraw or sharply delimit the "approved in principle" granted two years ago to the proposal of the Red Cross to establish a nation-wide blood donor and banking program.

The Reference Committee listened patiently and with obvious interest to the comments and suggestions of perhaps a score of witnesses from all parts of the country. Some of them, including high officials of the American Red Cross, defended the existing policy of their agency and made it clear that the policy of the Red Cross, nationally, is to encourage the development of full-scale bleeding and processing centers and to discourage or "take over" as rapidly as possible all local programs in which the Red Cross presently plays only a minor or contributing role.

Before this intention had been made clear and while the critics of the Red Cross program were being heard, your Executive Officer took occasion to offer a few suggestions based upon his experiences with the Red Cross in blood donor services in Westchester County, New York, in New York City and more recently in New Jersey. Emphasizing that he was speaking as an individual and not necessarily reflecting the attitude of The Medical Society of New Jersey, your Executive Officer suggested that the chief cause of conflict between the Red Cross and the medical profession in some areas seems to be an unwillingness on the part of the Red Cross to accept the role of a contributor or a supplementor of existing plans operated by the medical profession and voluntary hospitals. Instead of aiding or cooperating with these plans, he said, the Red Cross has frequently shown that it wants to supplant them with a preconceived program which, in some cases, could only weaken or dry up existing sources of supply for successful blood banks. A second major difficulty, he observed, seems to stem from a lack of flexibility on the part of regional and national A.R.C. officials who have discouraged (or refused to approve) local plans set up as a result of free negotiation and agreement between A.R.C. chapters and representatives of the medical, hospital and allied groups in many of the smaller communities. These plans were adjusted to local needs but not to the preconceptions of upper-echelon people in the National Red Cross.

The third major difficulty, your observer declared, is the provision required by the Red Cross in all blood donor programs in which it plays any part at all, that all blood obtained through such programs be given free of monetary or other obligation to any patient needing blood, regardless of the patient's financial resources. Insistence upon this, he said, eliminates the possibility of any hospital blood bank operating on the replacement principle and forces the medical profession to depend for its blood supply entirely upon voluntary public donations for which compelling incentives appear to be largely lacking under peacetime conditions.

Your observer further raised the question whether the progress of medical science would not be better served by the decentralization of blood banking through encouraging establishment of separate blood banks in every hospital large enough to maintain one, thus multiplying the number of opportunities for development of practitioners in hematology—rather than by centralizing blood donation and processing in a few major centers as contemplated by the A.R.C. national program.

Ultimately, the Reference Committee brought in a report which was unanimously adopted by the House of Delegates, reiterating the "approval in principle" extended by the A.M.A. to the Red Cross donor program.

However, the House called attention to the fact that:

> "Long before the Red Cross entered this field of medical practice there were many previously established blood banks operating successfully under local supervision. To disturb such independent local units would be unwise and disastrous, for they have repeatedly demonstrated their ability to meet local and regional needs. Furthermore, they have demonstrated the practicability of free enterprise and local initiative."

Therefore, the House construed its "approval in principle" as requiring: first, local control by the county medical society; second,

that the local medical society "be the initial contact in the contemplation or inauguration of a new blood bank"; third, that no publicity be released except by common consent of the county medical society and the local A.R.C. chapter; fourth, that differences of opinion in the establishment or operation of a blood bank, either administrative or technical, be arbitrated at the state level by joint committees from the medical society and the American Red Cross.

The House directed its national committee representing the A.M.A. to hold more frequent meetings and enlarged the committee to nine members, requiring it to report to the House of Delegates at each semi-annual session. The House further said:

"Any provision of free medical service or supply to everyone without regard to ability to pay is in opposition to the principle that it is the responsibility of an individual to assume the obligations of medical expense just as he does for other living expense. We deplore the use of the term 'free blood' in the publicity of the American Red Cross."

It is clear that in adopting this position, the House of Delegates has taken direct issue with a fundamental principle of the Red Cross in this project—namely, that all blood obtained in any program in which A.R.C. participates must be given without charge to any patient requiring such blood. It will be interesting to see how these antithetical principles can be reconciled—if, indeed, they ever can!

Medical Administrators Meet

One of the most rapidly growing yet least publicized organizations in the medical world is the Medical Society Executives Conference which, according to official definition, is "an association of executive employees of national, state, regional and county medical societies," whose purposes are "to enable medical society executives to improve the quality and efficiency of their services to their respective societies and to the medical profession generally; to provide a mechanism for the exchange of information and experience among medical society executives, for mutual improvement and for fellowship."

After having gathered informally at various times and places during the past decade, the medical society executives decided to effect a formal organization. The group held its first meeting during the course of the A.M.A. Convention in Atlantic City in 1947, and its second session was held this June, in Chicago.

The Conference now numbers more than 120 members including the vast majority of all eligible executive employees of recognized medical societies throughout the United States.

The second annual meeting of M.S.E.C. was an all-day affair, concluding with an evening banquet attended by 97 members and guests.

Mr. Mac F. Cahal of Chicago, Executive Secretary of the American College of Radiology, 1947-48, Chairman of the Conference, presided. Mr. Cahal succeeded Mr. Theodore Wiprud, Secretary of the Medical Society of the District of Columbia, in office. Mr. Wiprud was chairman during the first year of the Conference's formal existence.

The morning program was opened by a round table on "Administrative Procedures", moderated by Mr. Charles Crownhart, Secretary of the Medical Society of Wisconsin in which questions and comments were fired by the members at a board of four "experts".

After an hour and a half of round table discussion, the Conference went into executive session for its annual business meeting.

The afternoon session was opened with an address by Mr. Harvey T. Sethman, Executive Secretary of the Colorado State Medical Society on "Activating Public Service Programs for Medicine". Kenneth G. Hance, Assistant Dean of the School of Speech of Northwestern University addressed the group on "Parliamentary Procedure". This was followed by Willard H. Pedrick, J. D., Associate Professor of the School of Law of Northwestern University who spoke on "The Taxation of Medical Associations". Thereafter, Mr. Harry J. Owens, Advertising Manager of the Lakeside Press, Chicago, spoke on "Designing and Producing Promotional Literature". The formal program was concluded by a round table on "Convention Management" moderated by Mr. William J. Burns, Executive Secretary of the Michigan State Medical Society.

The newly elected chairman of the Conference is Mr. Nelson of the Ohio State Medical Association and the chairman-elect is your own Executive Officer, who has had the honor of serving the Conference as secretary and treasurer during its first two years. Succeeding him as secretary and treasurer is Mr. William F. Irwin, Executive Secretary of the Philadelphia County Medical Society. Other members of the executive committee are: Mr. Cahal and Dr. George F. Lull, Secretary and General Manager of the American Medical Association, who, incidently, is the number one charter member of the Medical Society Executives Conference. Twenty-two new members were elected during this second annual meeting.

James E. Bryan,
Executive Officer.

COUNTY SOCIETY REPORTS

SOMERSET COUNTY

H. E. Cook, M.D., Reporter

The June meeting of the *Somerset County Medical Society* was held June 17, 1948, at 6 p. m., at the Picnic Grounds of the Johns-Manville Corporation.

A real old-fashioned clambake—featuring clams, fish, lobster, chicken and liquid refreshments p.r.n., preceded the business session. The clambake was a huge success, with Bakemaster DR. SAMUEL H. HUSTED at the helm, DR. LEWIS C. FRITTS (Dispenser in Charge), and able assistance by Drs. Liddell, Glass, Tolomeo and Case. The food was delicious, no one left hungry, a very good time was had by all and the unofficial opinion was that this might well become an annual affair.

The business meeting was called to order at 8:45 p. m. with DR. A. F. MANGELSDORFF presiding in the absence of DR. G. E. BARBOUR.

The Nominating Committee recommended the following panel of officers for 1948-49, all of whom were unanimously elected: *President,* DR. A. F. MANGELSDORFF; *Vice-President,* DR. MASON W. H. PITMAN; *Secretary,* DR. IRVING KLOMPUS; *Treasurer,* DR. GODFREY S. HYER; *Custodian-Historian,* DR. LANCELOT ELY; *Censor,* DR. G. E. BARBOUR; *Delegates,* DR. L. C. FRITTS, DR. F. C. FIELD, DR. S. H. POGOLOFF, DR. R. F. HEGEMAN and DR. R. H. AMBROSE; *Alternate Delegates,* DR. A. J. STOLOW, DR. G. E. BARBOUR, DR. M. E. TOLOMEO, DR. B. ROSSI and DR. R. N. LIDDELL; *Delegate to Nominating Committee,* DR. L. C. FRITTS; *Councilor Members to Executive Committee,* DR. G. A. GLASS and DR. H. E. COOK.

Adjournment followed a standing applause of appreciation to the Bakemaster and his assistants for a very pleasant evening.

UNION COUNTY

E. M. Satulsky, M.D., Reporter

The Bristol Myers Company was host to the *Union County Medical Society* at its regular meeting on May 12, 1948, and the president, DR. R. M. NITTOLI, opened the meeting. Dr. Stevenson of the program committee introduced DR. WILLIAM S. LANGFORD, clinical professor of psychiatry, director of the psychiatric clinic and assistant attending pediatrician, Babies Hospital, New York City, who read a most interesting paper on "Physical Illness and Convalescence; Their Meaning to the Child". A question and answer period followed. The recording secretary read a letter from Dr. Royal A. Schaaf in which he expressed his appreciation to Dr. Davis and to the members of the county society for the cooperation he had been given during his year as president of The Medical Society of New Jersey.

The following applicants were elected to membership: DR. HENRY J. MINEUR of Cranford; DR. CHARLES L. LOMACK, of Westfield; DR. THEODORE LOIZEAUX of Plainfield; and DR. MORSE A. SHEPARD of Kenilworth.

Proposed amendments to the Constitution and By-Laws were read. *Constitutional Amendments. Article XII.* Section of the Constitution headed "Nomination for Officers, Committees and Delegates" shall be completely deleted and shall then read as follows: *Nominating Committee: Section 1:* A Nominating Committee of county wide distribution shall be named annually at the January meeting. It shall consist of five members appointed by the President and the Executive Committee. The Chairman of the Nominating Committee shall be a member of the Executive Committee. The duty of this Committee shall be to compile a list of all nominees for the several vacancies occurring among the officers and elected Committees of this Society and the State Delegates and Alternates, and a Member and an Alternate of the Nominating Committee of the State Society. *Section 2.* This Committee shall report its slate to the Executive Committee at a meeting called by the President, in ample time prior to the Annual Meeting, for its approval. Upon the approval of the Executive Committee, this report shall be mailed to all members of the Society, not later than February 15. Further nominations may be made upon the proposal in writing of any three members of the Society in good standing, if, and when, presented to the Secretary of the Society before February 28. *Section 3.* The nominations presented by the Committee shall be printed in a column on the left of the Official Ballot and any nominations made by petition on the right of the ballot, such ballot noting the names of the proponents. All of these nominations shall be printed and used as the Official Ballot of the Society at its Annual Meeting on the Second Wednesday of April. The polls shall be open from 7:30 p. m. to 10:00 p. m. on the night of the election, the ballot box being placed in a convenient location and not moved until after the polls are officially closed. Election shall be by individual ballot of members in good standing, personally registering with the Tellers at the Annual Meeting. A majority of votes cast shall be necessary to elect, except where there are more than two candidates for one office, a plurality shall elect.

Article XIII. Section 1 shall read: All elections for Officers, Committees, State Delegates and Alternates shall be at the Annual Meeting of the Society and by written ballot as specified under Article XII. *Section 2* shall be deleted. *Section 3* shall become *Section 2. By-Laws Amendments.* Under *Article III. Section 3* on the duties of the Recording Secretary add to the end of that Section the following: Preparatory to the Annual Meeting, he shall mail, on February 15, to each member, the nominations received from the Nominating Committee and also the final official ballot as determined February 28. He shall furnish the Tellers at the Annual Meeting, with a list of the members in good standing. *Article III. Section 10* shall be deleted and the other Sections shall move up each one number.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Robert B. Walker, President

"Four things a man should learn to do
If he would keep his record true
To think, without confusion, clearly
To love his fellow man sincerely;
To act from honest motives purely;
To trust in God and Heaven securely."

When I accepted the president's pin, I quoted these line from Henry Van Dyke as a symbol of my policy for the year. Today, when the world is seething with conflicting emotions, it is imperative that we think clearly and plan carefully at all times so that our work may not only be constructive but ever stimulating to those who will follow. To respect the opinions of others; to extend a friendly hand in time of trouble; to speak and think kindly of everybody at all times is the true essence of love. A sincere member will do only those things which are essential to the advancement of our auxiliary regardless of the personal gratification which may be involved. Let us follow closely these lines so that we may be of service to the profession of which we are privileged to be an auxiliary. Let us keep our record true!

AUXILIARY REPORTS

Bergen County

Mrs. Winton H. Johnson, Chairman of Publicity

The Woman's Auxiliary to the Bergen County Medical Society held its spring luncheon meeting at Nystrom's Restaurant in Paramus on Friday, May 14, 1948. Mrs. Floyd Keir, the president, conducted the business meeting and called for the reports of officers and committee chairman.

Mrs. Velma Garrett, membership chairman, told of the efforts being made to compile an accurate list of eligible and interested members who could be reached by personal letter or phone call.

Reports on the annual meeting of the State Auxiliary held during the Convention of The Medical Society of New Jersey at Atlantic City, April 26-29, were given by Mrs. Winton Johnson and Mrs. Anna Sexton.

Suggestions for a picnic social in June were proposed and enthusiastically accepted. The next business meeting will be held in the fall; in the meantime, under Mrs. Lois Mincke's chairmanship, the annual program bulletins will be printed and distributed. The meeting closed with group singing and selections by Mrs. Reichel, accordionist.

Camden County

Mrs. Wilmer F. Burns,
Chairman, Press and Publicity

The annual inaugural luncheon of *The Woman's Auxiliary to the Camden County Medical Society* was held May 4, 1948, at the Haddon Fortnightly, Haddonfield.

Mrs. Harold D. Barnshaw, Merchantville, was installed as president, succeeding Mrs. Arthur G. Pratt. Other officers taking part in the ceremony were: Mrs. Harold K. Eynon, president-elect; Mrs. Banks S. Baker, first vice-president; Mrs. H. F. Wescott, second vice-president; Mrs. Thomas H. McGlade, third vice-president; Mrs. Wilmer F. Burns, recording secretary; Mrs. William Browning, II, corresponding secretary and Mrs. Benjamin F. Lee, treasurer.

After the meeting the group was entertained with selections by the Auxiliary's chorus with Mrs. Ralph K. Bush as the accompanist. Another feature of the afternoon was the presentation of a one-act play entitled *White Iris* under the direction of Mrs. George B. German.

Hudson County

Mrs. Morris Bresev,
Chairman, Press and Publicity

The last regular monthly meeting for the current year of the *Woman's Auxiliary to the Hudson County Medical Society* was held Monday, May 3, 1948, at the Young Women's Christian Association building, Jersey City.

Mrs. William Gleeson gave a report on the recent state convention.

A motion was passed to accept the annual reports of the various committees.

A new committee on finance has been appointed for the purpose of working out an annual budget. The following were appointed: Mrs. J. Murphy, Mrs. F. Sachs and Mrs. A. Jaffin.

There was also a committee appointed to bring the constitution and by-laws up to date.

Plans were completed for the annual Play Day to be held at the Knoll Golf Club, Troy Hills. Mrs. Samuel Scott will serve as chairman, assisted by Mrs. Edward Waters, Mrs. Albert Lepis, Mrs. John Mackin and Mrs. Timothy Gerne.

Two new members were welcomed—Mrs. Vincent Campana and Mrs. Angelo Gnassi, both of Jersey City.

BOOK REVIEWS

Gifford's Text-book of Ophthalmology; rev. by Francis H. Adler, M.D., Professor of Ophthalmology, University of Pennsylvania School of Medicine. 4th ed. Illustrated. Pp. 512. Phila., W. B. Saunders Company, 1947. $6.00.

This revision of Dr. Gifford's text carries out the author's purpose of supplying a book suitable for the medical student and the physician not specializing in ophthalmology.

There are chapters on "Ocular Manifestations of General Diseases" and "Ocular Disorders Due to Disorders of the Central Nervous System". These and portions of other chapters should be helpful to the undergraduate student and the non-ophthalmic practitioner. In the chapter on "The Orbit" the subject of exophthalmos associated with thyroid disease is well presented and accompanied by illustrations which, like those throughout the book, are excellent.

In its 500 pages practically the whole field of ophthalmology is covered,—some subjects in considerable detail. It is, therefore, probably better suited to the graduate student or practitioner of ophthalmology, rather than to the undergraduate whose interest in, and time for this subject are usually limited.

A. RUSSELL SHERMAN, M.D.

Brief Psychotherapy. By Bertrand S. Frohman, M.D. 265 Pp. Lea and Febiger, Philadelphia, 1948. $4.00.

Perhaps it is too much to expect that any book can teach the technic of psychotherapy. Still this volume is advertised as "a practical handbook" and as "full of practical advice on treatment", and one has a right to expect therefore that the reader will come away with some down-to-earth ideas on treatment of the psychoneuroses. However what can the practitioner do with a report of a case treated by Wilhelm Stekel this way: "Stekel's compassionate and tolerant understanding provided emotional support. The supportive therapy assuaged her guilt." This is interesting, but unless the reader is a second Stekel, not very helpful.

At no point is the technic described. Instead the author crams the book with detailed case reports, showing how patients improved, but ascribing the improvement to such procedures as "correcting a tendency to react with insufficient delay" or "going directly into the basic meaning of the neurosis" or "presenting a summary of the ways in which kindness is inspired through constructive means". The case study method is suited to the guidance teaching of experts. It is poor pedagogy for the general practitioner, because he needs first a description of technics. Which is precisely what Frohman avoids. Even if the technics had been detailed, the non-expert reader could not have utilized them because his case never seems quite like the case in the book.

At one point the author starts out bravely correlating psychiatry with the several specialties. The reader expects that he will be shown how emotional components play a role in the diseases which all specialists have to handle. The chapter covers urology, endocrinology, gynecology and pediatrics and then grinds to a halt. The commonest psychosomatic syndromes (hypertension, peptic ulcer, asthma, and many others) are scarely mentioned. Maybe some day a wise and useful book will be written on psychotherapy for general practitioners.

L. J. BARONE, M.D.

Textbook of General Surgery. By Warren H. Cole, M.D., and Robert Elman, M.D. 5th ed. Pp. 1160. New York, D. Appleton-Century Company, 1948. $11.00.

This textbook is a "must" for every graduate student who is preparing himself for the American Board of Surgery. It is also instructive to the young surgeon who has already mastered the technic of the various operations and is now ready to acquaint himself with the physiology and pathology of the surgical diseases.

The subject matter is presented from a physiologic and pathologic point of view, so that the clinical features, diagnosis and treatment will be better understood.

Surgical pathology is fully illustrated by numerous photomicrographs and gross pathologic specimens. Non-operative therapy of the various surgical diseases is fully covered.

Operative procedures, although discussed, are not described in detail. For this, the authors have included an excellent bibliography of references and operative procedures in the various surgical conditions.

The chapter on shock and hemorrhage under the guidance of Blalock is short, complete and complies with the present day concepts. Dr. Evarts Graham edits an excellent chapter on surgical diseases of the chest. Orthopedics and trauma of the skeleton are well covered by such fine teachers as J. Albert Key and R. Arnold Griswold. The nervous system with its subdivisons is covered by Dr Naffziger in such a manner that a very difficult subject is made easy to understand. Dr. Whipple's personal experience in the Liver and Spleen Clinic at the Columbia Medical Center, contributes the most recent advances in subjects of utmost importance to the general surgeon.

Chemotherapy, water and acid-base balance, wound healing, infections of all kind and pre- and post-operative care are brought up to date in a very complete although concise manner. The compact chapters on genito-urinary surgery, gynecologic and military surgery are just enough to round out an excellent textbook for the young, graduate student. Even the experienced surgeon will find this book helpful.

M. A. ASHER, M.D.

Practical Child Guidance and Mental Hygiene. Samuel Kahn, M.D., Grace Kirsten, A.B., and May March, M.A. 285 pages. Meador Publishing Company, Boston, 1947. $4.00.

How can a mother stop a child from throwing things? The answer, according to this book is: explain to the child that it isn't nice. "The first time he throws something thereafter, it is evidence of negativity. This is an abnormal psychologic trait. Serious punishment is required to cure it." Believe it or not, this is the actual advice given by the authors, and is a fair measure of the soundness of the volume. The text is arranged in question and answer form. Thus, to a plea for help in understanding and treating fears, the patient and doctor are told: "These are symptoms of an early neurosis. The parents should study books in the field and get authoritative advice. Neurotic children often become neurotic or psychotic adults." This gives some idea of how useful the text is.

A harrassed parent wants to know how to handle temper tantrums. Here is the answer: "The child has been spoiled. Her frustration complex may become so severe. . . . that she will become irritable, selfish, even paranoid. Unless the parents acquire a thorough knowledge of child guidance quickly they should take the child to one who specializes. The manner in which the child is handled will have to be radically changed." This, of course, is a great help.

Fortunately the index is so poorly prepared that the average reader will be unable to track down his problem and thus be spared this kind of misinformation. For instance, the reviewer examined the index to find references to three common problems—enuresis, profanity, and spanking. Not one of the items was listed in the index, though they are all discussed somewhere in the book.

Want to know how to treat bed-wetting? Here is the technic as given by the authors: "It has often been thought, but seldom proved, that enuresis is a kidney, bladder, or physical difficulty. Psychologic and educational treatment usually leads to proper habit formation and cure."

Had enough?

HENRY A. DAVIDSON, M.D.

Unipolar Lead Electrocardiography. By Emanuel Goldberger, M.D. Pp. 182 with 88 illus. Phila., Lea & Febiger, 1947. $4.00.

About fourteen years ago Frank Wilson described a method for obtaining electrocardiograms that represented the potential variations of a single electrode. He used this for obtaining unipolar extremity and precordial leads. However, until recently few clinicians have shown interest in unipolar electrocardiography. The author of this volume has been one of the few.

The book presents the essentials of unipolar electrocardiography. The technic of taking unipolar leads and augmented unipolar leads is explained in detail. The normal electrocardiogram is discussed with explanations of the effects of various positions of the heart. There are chapters on hypertrophy, bundle-branch block, and myocardial infarction.

All conditions, normal and otherwise, are described in terms of five basic patterns. The genesis of each pattern is illustrated by diagrams showing the spread of the excitation process through the heart. Such explanations should prove valuable to the beginner.

To keep the book brief the author had to exclude much, but the selection of material and its presentation are well done. Since controversial issues are avoided, the tone is somewhat dogmatic.

Perhaps a little more detail on the T-wave might have been included. At least it seems some discussion of primary and secondary T-Wave changes might have made the attempt to differentiate "ventricular hypertrophy" pattern from "ventricular strain" pattern a little clearer. In the final chapter on digitalis effects, the T-Wave changes are discussed simply and clearly. Also a brief note explaining why unipolar limb lead potentials are so small might have been included, since the augmented unipolar lead is one of the author's contributions. On these and other points the decision to exclude required considerable, careful thought. The result is a compact little book.

To this reviewer the most important advantage of unipolar leads is that they make spatial electrocardiography a practical office procedure. Using an exploring electrode coupled with a central terminal, the clinician may explore any part of the body surface and interpret the resulting electrocardiograms with ease.

The illustrations are ample and include many electrocardiograms, all of which are described in detail in the text.

DAVID BIBER, M.D.

Diseases of the Nose, Throat and Ear. By William L. Ballenger, M.D., and Howard C. Ballenger, M.D., assisted by John J. Ballenger, M.D., Pp. 993, 9th ed., 597 illustrations; Phila., Lea & Febiger, 1947. $12.50.

The changing status of otolaryngology is reflected in the ninth edition of this well-known text book. The past ten years of investigation have shown progress in the understanding of diseases and disturbances of the upper respiratory tract. The authors have incorporated these newer ideas into their text.

This edition has been brought up to date by the inclusion of subjects such as headaches, neuralgias, neuroses about the head and respiratory tract, plastic reconstructions of the nose, allergic disorders of the respiratory tract and aeration otitis.

The general body of the text is concise and clear. The illustrations are pertinent and informative. For general reference, for students or practitioners, it organizes the field of otolaryngology in a definitive and practical manner. Dr. Ballenger's book has been a classic for many years and in this new edition its tradition of excellence is maintained.

LOUISE FISCHER, M.D.

Congenital Malformations of the Heart. By Helen B. Taussig, M.D. Pp. 654 with 46 plates in color and 178 black and white illustrations. New York, The Commonwealth Fund, 1947. $10.00.

In 1945, there appeared in the Journal of the American Medical Association the now classic paper by Blalock and Taussig on the surgical treatment of malformations of the heart with pulmonary stenosis or pulmonary atresia. A footnote stated that a book on "Congenital Malformations of the Heart" was "forthcoming". This long awaited book has now been published, and it is all that we expected.

The book is based entirely on Dr. Taussig's vast experience at the Harriet Lane Home in Baltimore. Dr. Taussig states in her preface that she has no personal experience with angio-cardiography, and so this method of investigation is just briefly discussed. This is decidedly to the advantage of the reader because Dr. Taussig shows convincingly that a precise diagnosis can be made in most cases of congenital malformations of the heart by the methods that the average physician, interested in heart disturbances in children, has at his disposal.

This is a valuable contribution because Dr. Taussig clearly shows that the configuration of the heart in children differs from the configuration in adults, and that the manifestations of changes in the size of the various chambers of the heart is not the same as in adults. This volume will be of great value to all physicians who deal with children, and is especially recommended to cardiologists, for the lucid presentation of the clinical and fluoroscopic signs of the various malformations of the heart in children.

William H. Fost, M.D.

Pneumoperitoneum Treatment. By Andrew Ladislaus Banyai, M.D. Pp. 376 with 74 illus. St. Louis, C. V. Mosby, 1946. $6.50.

This treatise on treatment by pneumoperitoneum should be of particular interest to the chest physicians in this section of the country. Certain procedures are identified with certain physicians and favored in their particular areas. Dr. Banyai has always championed pneumoperitoneum and he is one of its most renowned proponents. The procedure has gained favor during the past few years, as evidenced by the large series of cases being reported, particularly from sanatoria in the south. I recall the extreme skepticism and cold indifference that met the author's paper locally in 1936, in contrast with the close interest and attention accorded this topic at the last gathering of chest physicians.

The book is written in conversational and informal tone. It makes easy and interesting reading. The chapters are replete with x-ray reproductions of good quality, which clearly illustrate the "before and after" of pneumoperitoneum therapy. The author attaches greatest importance to his chapter on technic. The procedure is described at length with meticulous attention to detail, although every paragraph is somewhat overburdened with opinions and references of other authors. (There are 524 references).

The chapters on pneumoperitoneum therapy in pulmonary and abdominal tuberculosis are perhaps the most important. Indications, contraindications and complications are discussed with clarity, and the value of preliminary phrenic paralysis (as an adjunct) is stressed considerably.

The references to the small series of cases reported by other authors with their comparatively low ratios of arrested cases and their emphasis on symptomatic improvement rather than sputum conversion rates, does nothing to encourage the uninitiated, nor does it stimulate further interest in those who have had only mediocre success in their own modest series.

The value of the procedure in other non-tuberculous pulmonary and abdominal conditions is covered briefly in the last chapters. More might have been said about the gratifying benefit afforded the patient who is suffering from pulmonary emphysema with fixed diaphragms and invalided by extreme dyspnea and ineffectual cough.

There should be sufficient fundamental interest in this volume to warrant its addition to the bookshelf of all men concerned with collapse therapy, whether or not they are in agreement with the author's concepts of therapy.

Martin Castellano, M.D.

Advances in Internal Medicine. William Dock, M.D., and I. Snapper, M.D. New York, Interscience Publishers, Inc., 1947. $9.50.

This excellent collection of articles includes a discussion of recent approaches to the field of internal medicine by well known authorities in their various areas. Among the subjects are venous catheterization studies in cardiac failure, surgical treatment of hypertension, physiologic aspects of aviation and deep sea diving, rhesus antigen problems, and megaloblastic anemias. The authors of the articles could not be more aptly selected. Alexander S. Wiener writes on rhesus antigen; Marcy Sussman on angiocardiography. The fields of endocrinology and metabolism are not touched in this volume. The material is not original, but it comprises under one cover a good cross section of the important advances within the last few years.

Frank N. Wilson and others cover the interpretation of the ventricular complex in electrocardiography, in a fairly comprehensive article summarizing the theories of interpretation and emphasizing the importance of correlating the clinical and graph findings. There is also some discussion of the unipolar leads.

To the reviewer, one of the most interesting articles was the one by Snapper on nutrition in the Orient. In a style quite different from that of the ordinary medical article, the author takes one through the apparent latitudes of human nutritional tolerance as exemplified by the diets of the peoples of the Far East. The observations tempt one to reflect and perhaps revise some of the concepts of our own requirements. Diets in India and China, which do not permit proper health in some respects, in no way seem to inhibit the propagating qualities of these peoples.

Everett O. Bauman, M.D.

Synopsis of Allergy. By Harry L. Alexander, A.B., M.D., 2d ed., Pp. 255. St. Louis, Mo., The C. V. Mosby Co., 1947. $3.50.

This is a timely synopsis for the general practitioner. The phenomena of atopy, hypersensitiveness, and asthma, as well as other allergies including allergic dermatoses are clearly discussed.

The pharmacology and action of drugs used in allergy are explained. Therapeutic suggestions and valuable tables are included which should be of interest to all doctors. The technics of testing for allergic syndromes are outlined.

For the busy practitioner, this synopsis offers a most useful reference manual and a brief review for the allergist of the present-day approach to allergy.

E. P. LEVINE, M.D.

Thematic Apperception Test by Silvan S. Tomkins, Ph.D., New York. Grune & Stratton, 1947. $5.00.

What a person says or writes about himself, what he reveals in an interview, or answers in a questionnaire, by no means completes the account of his personality. To draw the facts from the invisible regions of mental activity, seemingly roundabout psychologic methods must be applied. One such group of methods consists of "projective technics". In these, the subject is confronted with an ambiguous situation, is asked to do something with it, and is thus given wide freedom of action. Favorable conditions are therefore created for unself-conscious revelation from the hidden regions of personality.

The Thematic Apperception Test (TAT), introduced in 1935 by Morgan and Murray, is useful in ellciting the "content of personality, the particular images, strivings and sentiments which have been developed in the course of individual experience". Unlike the Rorschach Test which employs a series of abstract, unstructured blots, the TAT material consists of concrete, structured pictures which the subject is asked to use as a starting point for fantasy. Also unlike the Rorschach, which is now well established, the TAT is but in its infancy. Dr. Tompkin's book is written with this in mind. It is directed to those who are completely unfamiliar with the test, and to research psychologists whose interest in the potentialities of the test he hopes to arouse. That the test has validity and stability appears probable from the literature and from the case material contained in this volume.

Written in clear, easily-readable manner, the first portion covers the historical development of the test, its technic of application, scoring and interpretation. This is followed by a discussion of the level of analysis investigated and of the diagnosis of the personality. Finally, on the basis of the psychopathology revealed, therapy is discussed.

The TAT cards are not supplied with the book, so that a reader cannot learn how to administer or interpret the test simply by studying this volume. The book is too esoteric to appeal to medical practitioners whose work lies outside the field of psychiatry. Psychiatrists who are familiar with testing technics and who have equipped themselves with a set of the Morgan-Murray cards will find the book useful. It is a compact and handy manual for psychologists and psychometrists.

ARTHUR KALLEN, M.D.

Diagnosis and Treatment of Diarrheal Diseases. By W. Z. Fradkin, M.D. Pp. 254, New York. Grune and Stratton, Inc., 1947. $5.00.

Dr. Fradkin has earned the gratitude of clinicians in general and gastroenterologists in particular for having placed before them a concise and comprehensive book to which one can frequently turn for practical guidance in the diagnosis and management of diarrheal disease.

The geographic distribution of these diseases emphasizes the ubiquitous protozoan, bacterial and parasitic diarrheas. The most common ones in this country are treated in greater detail. He also includes diarrheas due to glandular dysfunction, mechanical factors and neoplasms, vitamin deficiencies, allergy, chemical poisoning and psychogenic causes. There is a chapter on infant and children's diarrhea.

The author presents illustrations of his office diagnostic set-up which includes the rectosigmoid aspirator devised by him. The latter is a distinct advance and this reviewer regrets that we have been deprived of a tabulation of his five hundred cases with which we could compare our own.

Detailed roentgen studies are presented and the importance of painstaking frequent fluoroscopy in suspected small bowel lesions is emphasized. This should arouse those clinicians who delegate to others the radiographic studies into inquiring as to whether this all important procedure has been followed; otherwise such diseases as tuberculous enteritis, regional ileitis and idiopathic steatorrhea will be overlooked.

Special chapters are devoted to regional ileitis and idiopathic, chronic ulcerative colitis. The author's concept of psychogenic disturbances plus pathogen playing a combined role in the pathogenesis of ulcerative colitis is quite acceptable in these days of emphasis on psychosomatic medicine alone. His reports on medical treatment of ulcerative colitis serve as a reminder that surgery in this disease should be resorted to only for complications.

Concerning the diarrheas caused by intestinal worms, judging from the numerous illustrations of his own, the author must have had a large experience. The preparation of patients prior to administration of specific therapy is given. He reports the astounding figure of forty-eight million Americans affected with trichinosis. The high infant mortality rate from diarrhea (9,763 in 1943), is also a challenge deserving of our attention.

On the whole, this is a compact, readable and thought-provoking volume.

I. GELBER, M.D.

Colloid Science, A Symposium. By E. K. Rideal, Pp. 208. Brooklyn, New York, Chemical Publishing Company, Inc., 1947. $6.00.

This book is composed of a series of lectures given as a course in colloid science at Cambridge University, England. It deals mainly with the general principles of colloid chemistry and includes some applications of these principles. The volume is highly condensed, and would require extensive supplementary reading, should a fundamental grasp of the subject be desired. However, the lectures make fairly easy reading, and numerous diagrammatic drawings illustrate the text.

Two chapters would have special interest for the physician. One, on surface chemistry and colloids, deals mainly with foams and emulsions and includes the theory of emulsification, types of emulsions and emulsifying agents. The second, on emulsions *in vivo*, treats the subject of fat metabolism and the effect of bile salts, oleic acid, cholesterol, etc., on emulsification and absorption of fat through the intestinal wall. The rest of the book relates mainly to the theories of colloid systems and to methods by which these systems are studied.

This book should appeal to the medical chemist and the physiologist, because of the obvious importance of colloid systems in vital processes.

John M. Cross, Ph.D.

Ear, Nose, and Throat; Symptoms—Diagnosis—Treatment. By George D. Wolf, M.D., Pp. 523, Philadelphia, Pa., J. B. Lippincott Co., 1947. $10.00.

Dr. Wolf has written an essential basic text in otolaryngology for the student, intern, and general practitioner. The author has outlined and discussed related symptoms. In the chapter on "Emergencies", Dr. Wolf covers hemorrhages of nasal origin, of the throat, from the ear; foreign bodies in the nose, ear, pharynx, air and food passages; and also emergency tracheotomy. In another chapter he effectively writes on the mechanism of head pains as well as the points of origin and causes of headache. He then goes into a complete differential diagnosis of headaches originating from nasal, otitic, and ocular causes, allergic headaches, histamine psychoneurotic and the headaches from intracranial lesions.

In a similar fashion, using a symptom complex as a guide, Dr. Wolf takes into consideration "obstructed nasal breathing", "post-nasal drip", "sore throat", "hoarseness" and "obstructive dyspnea".

By the minor emphasis on surgical procedures, the author has made the text more desirable since such technic can be perfected not by reading alone, but by observing, assisting, and performing the operations under competent guidance. The author does not pad the book with exhaustive descriptions of operations which would be of no practical value to the reader. On the other hand many concrete valuable suggestions which can be applied in daily practice are offered in most of the chapters.

There is very little mention of broncho-esophagology. Since this is a sub-specialty in otolaryngology, and a very highly technical field, it would be of little value to the average reader.

The writer has included such topics as "swelling of the salivary glands", "disturbances in the sense of taste" and even "snoring".

This book successfully accomplishes its aim in presenting to the student, intern and general practitioner, a compact and handy guide in otolaryngology.

Francis S. Weinstein, M.D.

Psychiatry for the Pediatrician. By Hale F. Shirley, M.D. Pp. 442. The Commonwealth Fund, New York City, 1948. $4.50.

Most texts on child guidance prove to be unsatisfactory. Some, like Kanner's *Child Psychiatry* are so filled with generalities and theoretical material, that the bewildered reader is left with a sense of frustration when he wants to know how to tackle a specific guidance problem. Others, like Kahn's *Practical Child Guidance* are made up almost entirely of little mechanical tricks which convey nothing of the depth of the problem or the meaning of the symptoms.

Shirley's *Psychiatry for the Pediatrician* skilfully steers a middle course. It furnishes enough of the theoretical background to give child guidance its proper setting; but all this general material is anchored to the realities of practice. Every concept is illustrated by a case, presenting a common problem, which serves at once to exemplify the concept and clothe it with reality. At the same time, adequate space is devoted to the actual day by day management of child guidance problems.

The book starts with a fifty-page monograph on the basic concepts of child guidance. This is followed by a chapter on normal development and habit training that enables the practitioner to see each case in longitudinal view. The "patient" after all comes to the office in cross section, at a particular moment in his development, for the relief of a particular battery of symptoms. This section adds a new dimension to the static picture presented by the case clinically. Extensive chapters are then offered, covering the physical, intellectual and emotional factors, followed by a sane analysis of the role of environmental stresses. The technics of investigation are then reviewed. The final chapter describes the methods of information giving, persuasion, suggestion, and mobilization of community and other resources which, in the aggregate, make up the fabric of treatment. On the whole, it is a wise, readable, and useful book, avoiding the pompous emptiness of pseudo-psychiatric jargon, and salting its examples and suggestions with wit, humor, and a nice sense of proportion.

Ralph N. Shapiro, M.D.

Practical Emulsions. By H. Bennett, Pp. 568. Brooklyn, New York, Chemical Publishing Company, Inc., 1947. $8.50.

This is an understandable, not too technical discussion on emulsions, emulsifying agents, methods of preparation, and the listing of formulas. It is not intended for physicians, but is designed to give information useful in manufacturing. There is one chapter on medicinal emulsions which may be of value to some practitioners.

Thomas D. Rowe, Ph.G.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **August, 1948** **No. 8**

BCG vaccine, prepared under ideal conditions and administered to tuberculin negative persons by approved techniques, can be considered harmless. On the basis of studies reported in the European and American literature, an appreciable reduction in the incidence of clinical tuberculosis may be anticipated when certain groups of people who are likely to develop tuberculosis because of unusual exposure, inferior resistance, or both, are vaccinated.

BCG VACCINATION IN ALL AGE GROUPS

BCG (Bacillus of Calmette and Guerin) is a bovine tubercle bacillus isolated in 1906. The virulence of the organism was reduced by culturing it on a bile potato medium for 13 years. This avirulent organism when inoculated into animals produced local nodular lesions without progression or generalization of the process. Shortly thereafter the inoculated animals showed a measure of resistence to progressive infection with virulent tubercle bacilli. With the assurance that the organism was harmless and that it offered a degree of protection against virulent tubercle bacilli, human application was begun in 1921 in Paris. Since that time it is estimated that some ten million vaccinations have been performed throughout the world.

The study reported here represents the longest continuous experiment on BCG vaccination in the United States. From experience over a period of 13 years, it can be stated unconditionally that BCG is safe, a fact that has had verification the world over.

The major premise of this study was that BCG should supplement present methods of early diagnosis and segregation. The manner of application of the BCG vaccine was by the multiple puncture method. In thousands of vaccinations by this method complications have been practically nil.

The groups studied were:

1. *Newborn Infants* — The children in this group came from households in which no tuberculosis could be demonstrated by roentgen examination. The infants were vaccinated or accepted as controls before they left the hospital, and no isolation was practiced.

There were 1,417 infants vaccinated during the first week of life. Three months later over 99 per cent of these infants had become tuberculin positive. Six and a half years after the single vaccination almost 80 per cent of those tested were still tuberculin positive. Among the 1,414 infants in the unvaccinated control group, 44 per cent were positive at the end of eight and a half years. This high rate of tuberculin conversion of the controls indicates the degree of exposure for both vaccinated and control groups.

There were 11 cases of tuberculosis with one death in the vaccinated group and 39 cases with seven deaths in the controls. This study has been in progress for 10 years.

2. *Infants Born of Tuberculous Parents*—Isolation was practiced for the controls and vaccinated alike for a period up to 12 weeks. Children were returned to their families only if examinations of concentrated sputum of the tuberculous member were negative.

There were two cases of tuberculosis in the vaccinated group of which one was hospitalized and none died as compared with five cases in the control group all of which were hospitalized and four died.

3. *Student Nurses* — Entering students were tuberculin tested and vaccinated and did not go in wards for a month. The vaccinated student nurses worked in the tuberculosis hospital while the control negative reactors did not. Despite the difference in exposure no cases of pulmonary tuberculosis developed among 142 vaccinated nurses and there were three cases in the 199 controls. There

were three additional cases among the tuberculin positive reactors. This study has been in progress for seven years.

4. *Medical Students* — These students were X-rayed and tuberculin tested, and 109 negative reactors who desired it were vaccinated. The control group consisted of those who refused. Among the vaccinated there were no cases of pulmonary tuberculosis but four cases were reported in the nonvaccinated group. This study was begun seven years ago.

5. *Children in a Federal Housing Project* — The entire community was first examined roentgenologically and those with active pulmonary disease were isolated. Alternate children who did not react to tuberculin were vaccinated. In the 625 unvaccinated negative reactors there were four cases of tuberculosis and no deaths. Among the 275 tuberculin positive reactors there were two cases of active tuberculosis with one death. Another death from tuberculosis occurred in a child whose tuberculin reaction was not recorded but whose original X-ray of the chest was negative. There were no cases among the 699 vaccinated children. This study is now in its sixth year.

6. *Inmates of a Mental Institution* — After a roentgen survey and tuberculin testing, the persons with active disease were isolated. Seven months after retesting, alternate negative reactors were vaccinated. There was no pulmonary tuberculosis in the 20 patients vaccinated and one case of bilateral minimal arrested pulmonary tuberculosis in 15 controls.

The efficacy of the vaccine appears well documented in this study. The morbidity and mortality rates from tuberculosis were reduced appreciably after vaccination. The extent, severity, duration and sequelae of the pulmonary lesions when they did occur in the vaccinated were less extensive, of shorter duration and calcified earlier than those in the nonvaccinated.

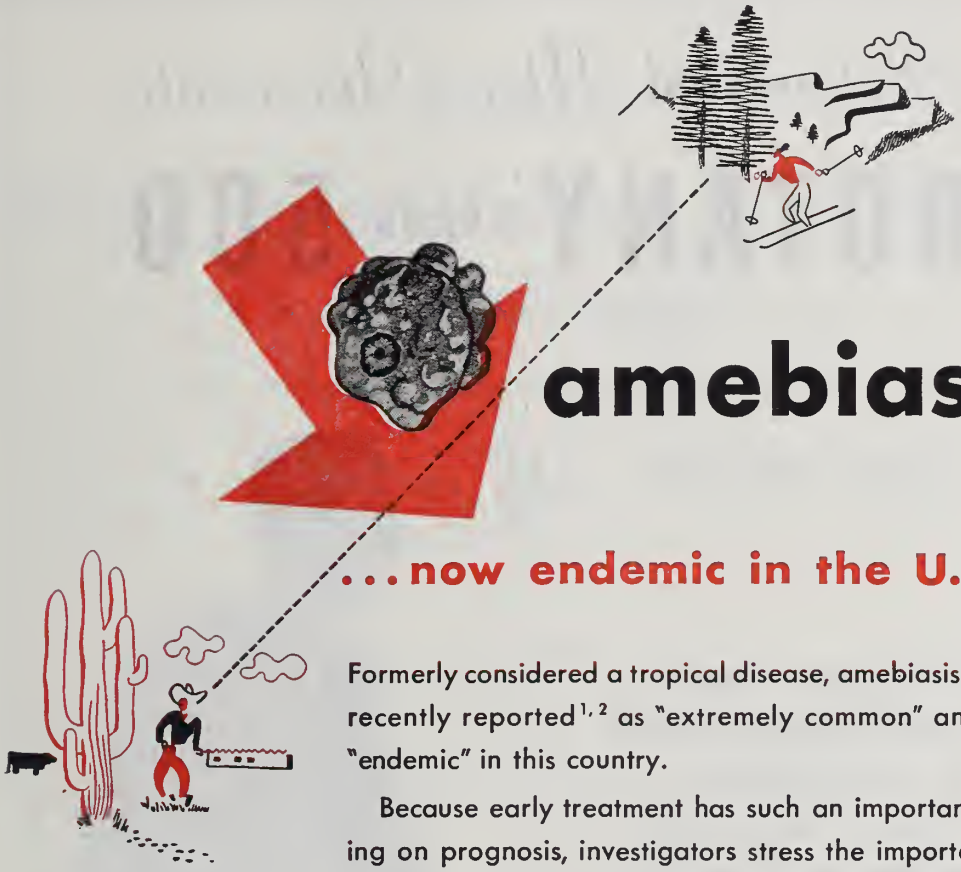
The portion of our population who would benefit most by the vaccination would seem to be those from susceptible races and those unduly exposed to tuberculosis in all age groups. It is again stressed that those who are vaccinated should have a period of at least one month before and after vaccination when there is no direct contact with virulent tubercle bacilli.

BCG Vaccination in All Age Groups, Sol Roy Rosenthal, M.D., Eleanor I. Leslie, M.D., and Erhard Loewinsohn, M.D., The Journal of the American Medical Association, January 10, 1948.

SUPPLIED BY

NEW JERSEY TRUDEAU SOCIETY,
the medical section of the

NEW JERSEY TUBERCULOSIS LEAGUE
15 East Kinney Street, Newark 2, New Jersey



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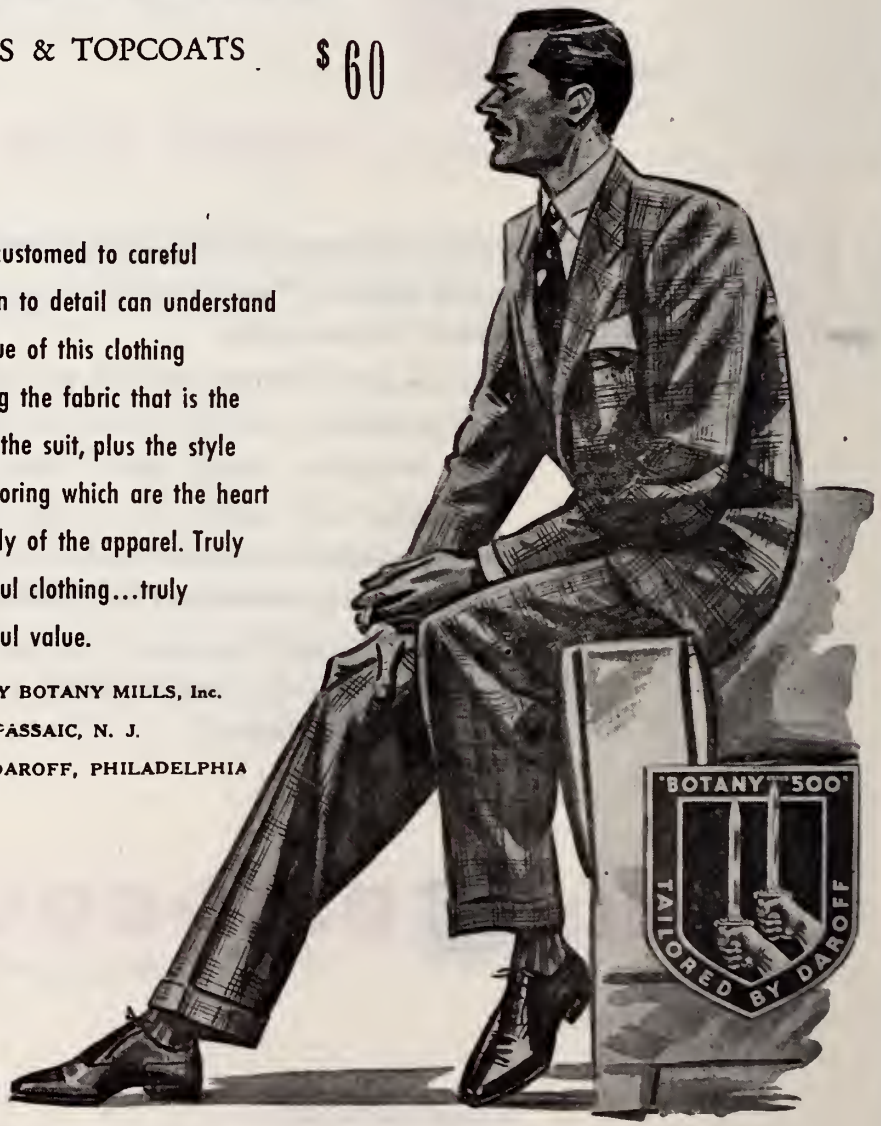
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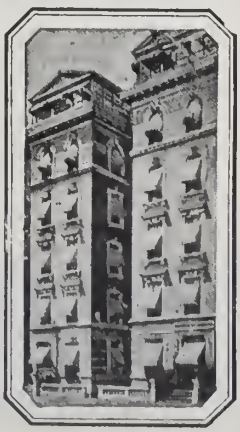
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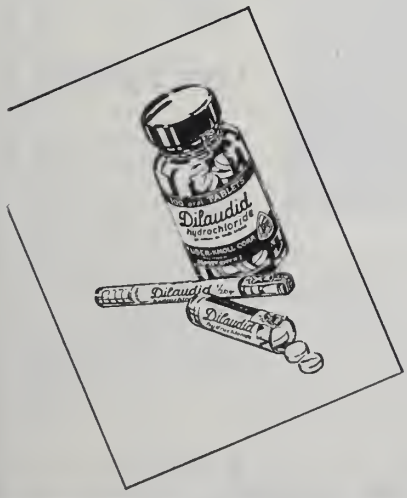
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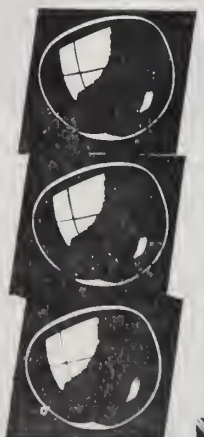
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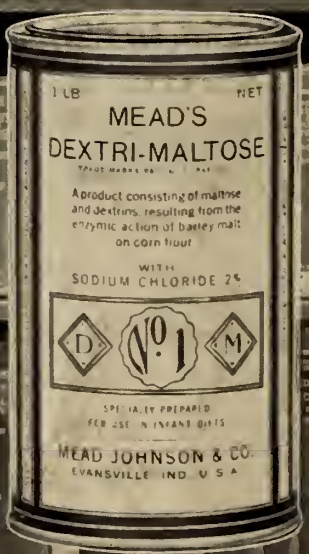
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PERCENTAGE COMPOSITION
(NOT calculated to 16% Nitrogen)

Arginine*	3.8
Histidine*	2.7
Isoleucine*	8.0
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Lysine*	8.2
Methionine*	3.0
Phenylalanine*	5.1
Threonine*	4.4
DL-Tryptophane	1.0
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Other Amino Acids	42.0

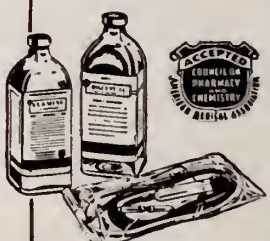
Total Nitrogen‡	13.4
a-Amino N††	10.0
% a-Amino N of Total N‡	75.0
Ash—on ignition	1.0
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NaCl	less than 0.05

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☆ Virtually salt-free ☆ practically neutral in reaction ☆ each bottle contains 60 grams of *free* amino acids—an amount sufficient to satisfy the daily nitrogen requirements of the average surgical patient ☆ well tolerated in 10% solution

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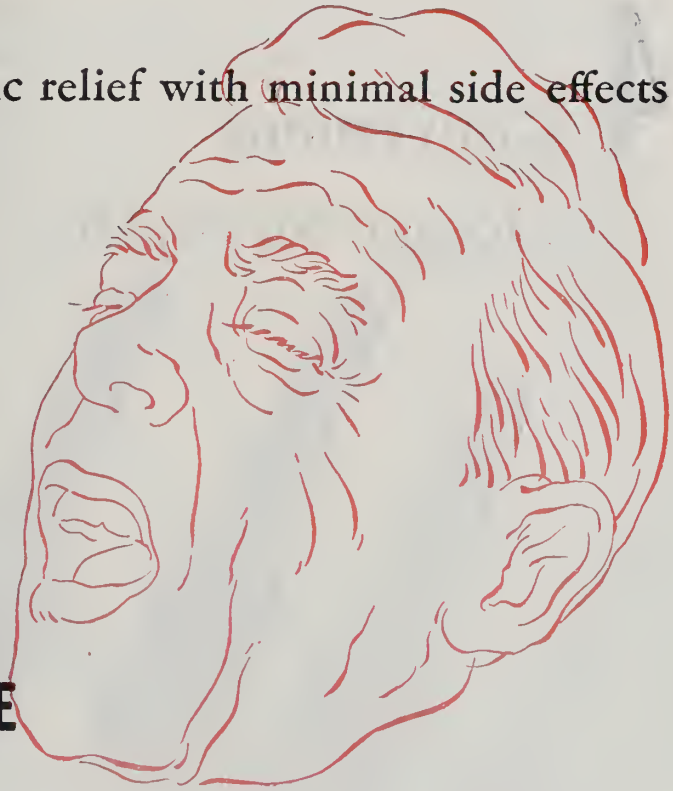
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SIMILAC *Similar to breast milk*

symptomatic relief with minimal side effects



in
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1. ARBESMAN, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. LOVELESS, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. BERNSTEIN, ROSE and FEINBERG: *Ill. Med. Jl.*, 92: 2, 1947.
4. OSBORNE, JORDON and RAUSCH: *Arch. of Derm. & Syph.*, 55: 318, 1947.

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(Solution Gold Sodium Thiomalate Merck)

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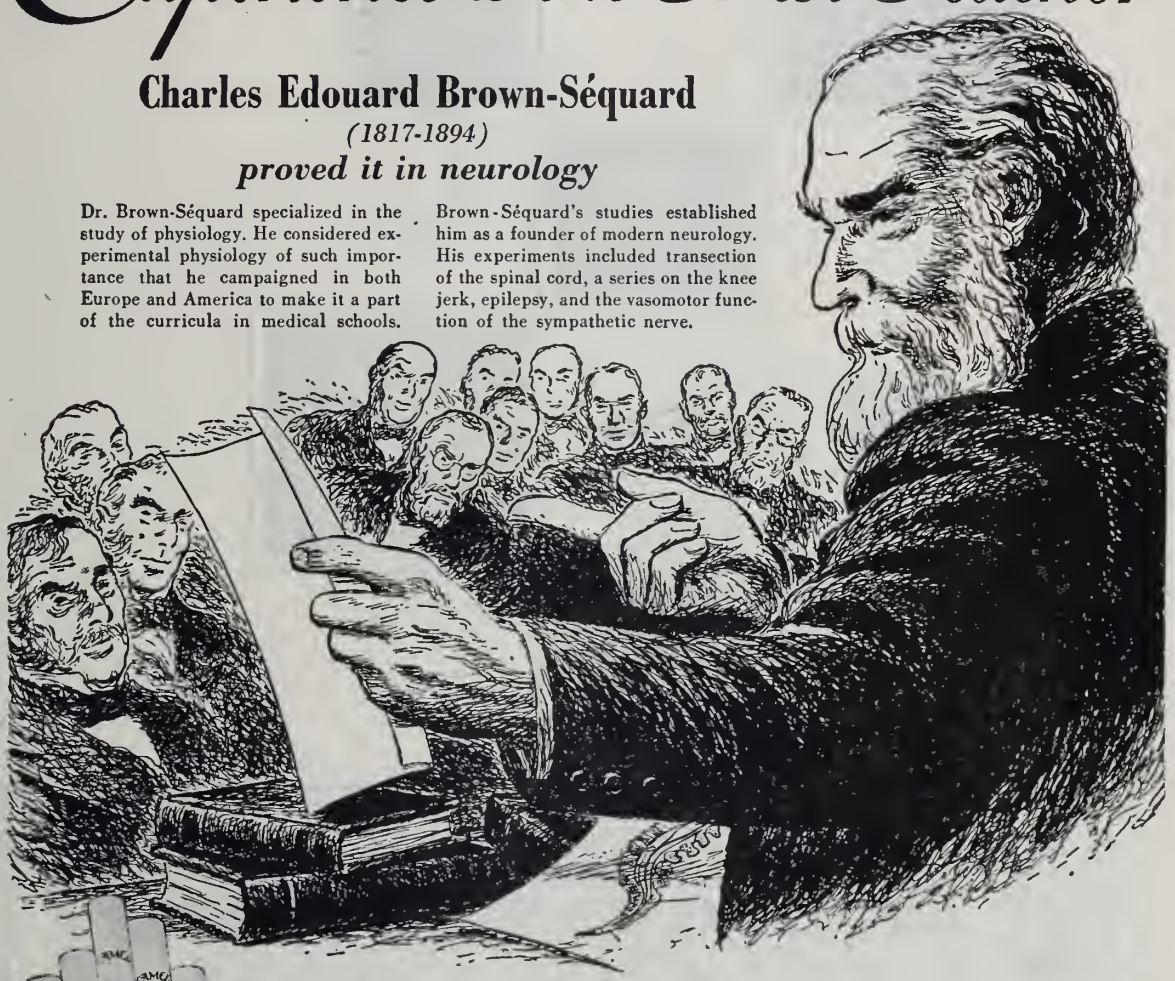
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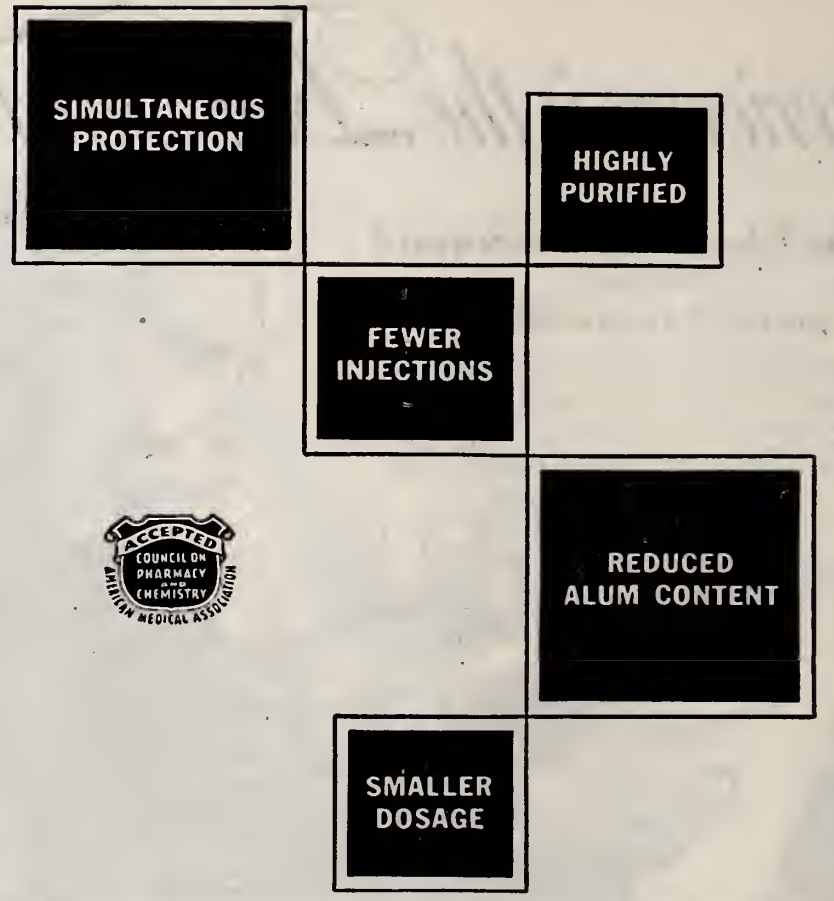
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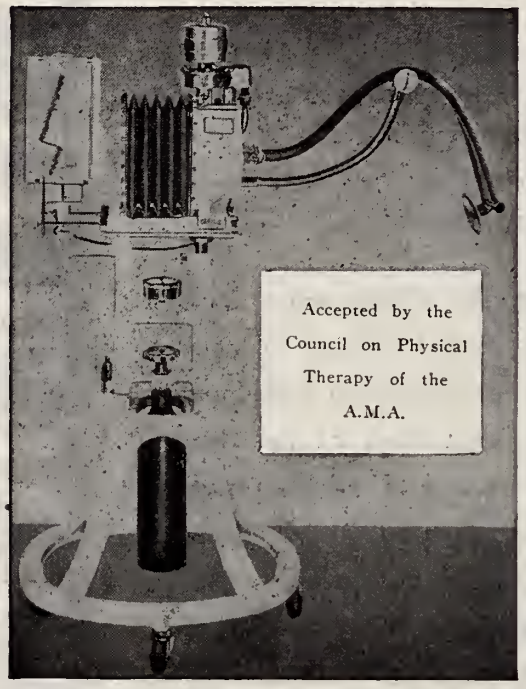
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Recent evidence[1,2] indicates that the presence of fat in a mixed dietary considerably decreases the specific dynamic effect of the three basic nutrients, thus promoting optimal utilization of the protein ingested.

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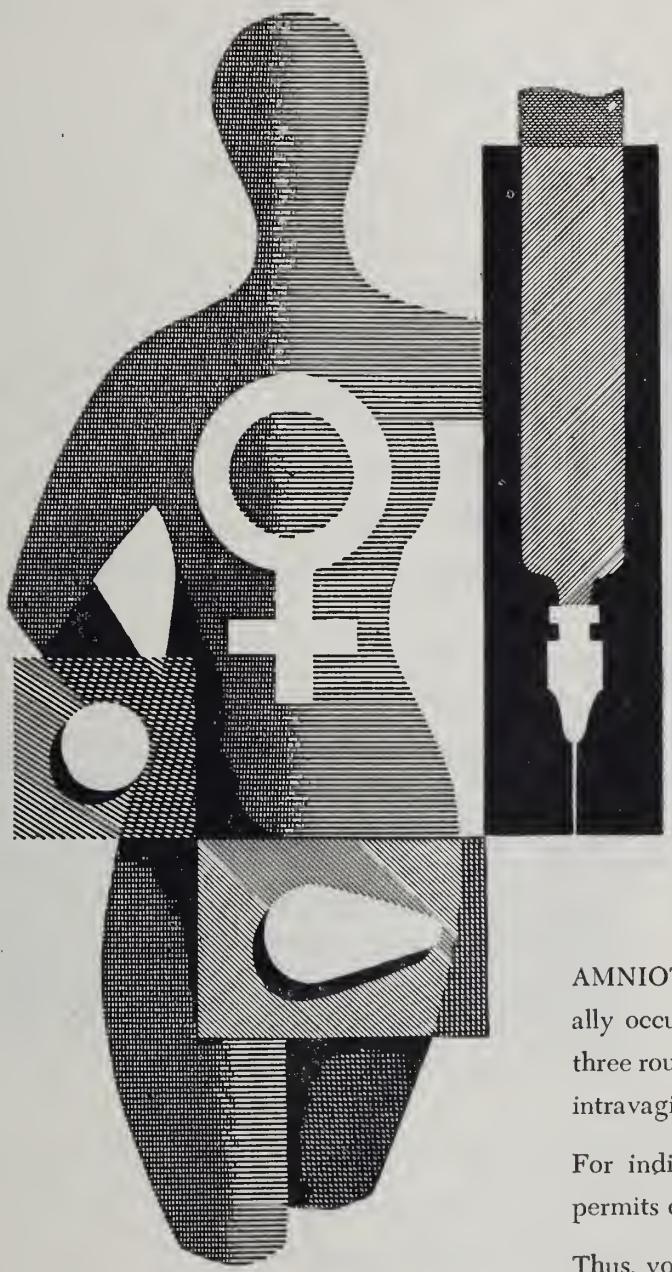
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[1] Forbes, E. B., and Swift, R. W.: J. Nutrition 27:453 (June) 1944. [2] Forbes, E. B.; Swift, R. W.; Elliott, R. F., and James, W. H.: J. Nutrition 31:203;213 (Feb.) 1946.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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AMNIOTIN is the only complex of naturally occurring mixed estrogens for use by three routes — intramuscularly . . . orally . . . intravaginally.

For individualized therapy, AMNIOTIN permits dosages of 1,000 to 50,000 I.U.

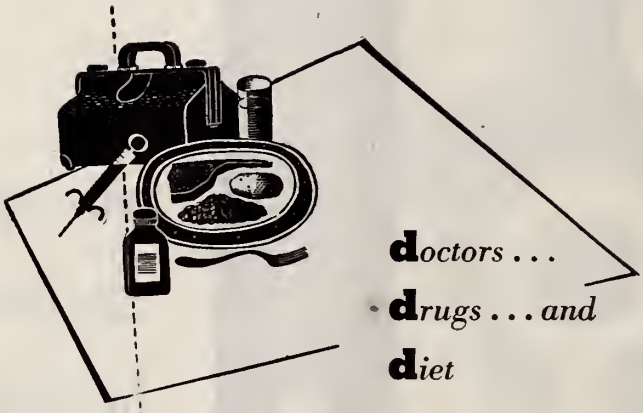
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In spastic colitis the therapeutic triad is doctor, drug and diet—simple psychotherapy . . . an effective antispasmodic . . . and a bland diet. In this regimen Syntropan "allows more discreet therapeutic results . . . relief of spasm without accompanying mydriasis, dry mouth, and changes in cardiac rate."[1] The dual antispasmodic action of Syntropan affects the parasympathetic nerve endings like atropine, the smooth muscle cells like papaverine. Tablets of 50 mg. and 100 mg.

1. Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, Macmillan, 1947, P. 478.

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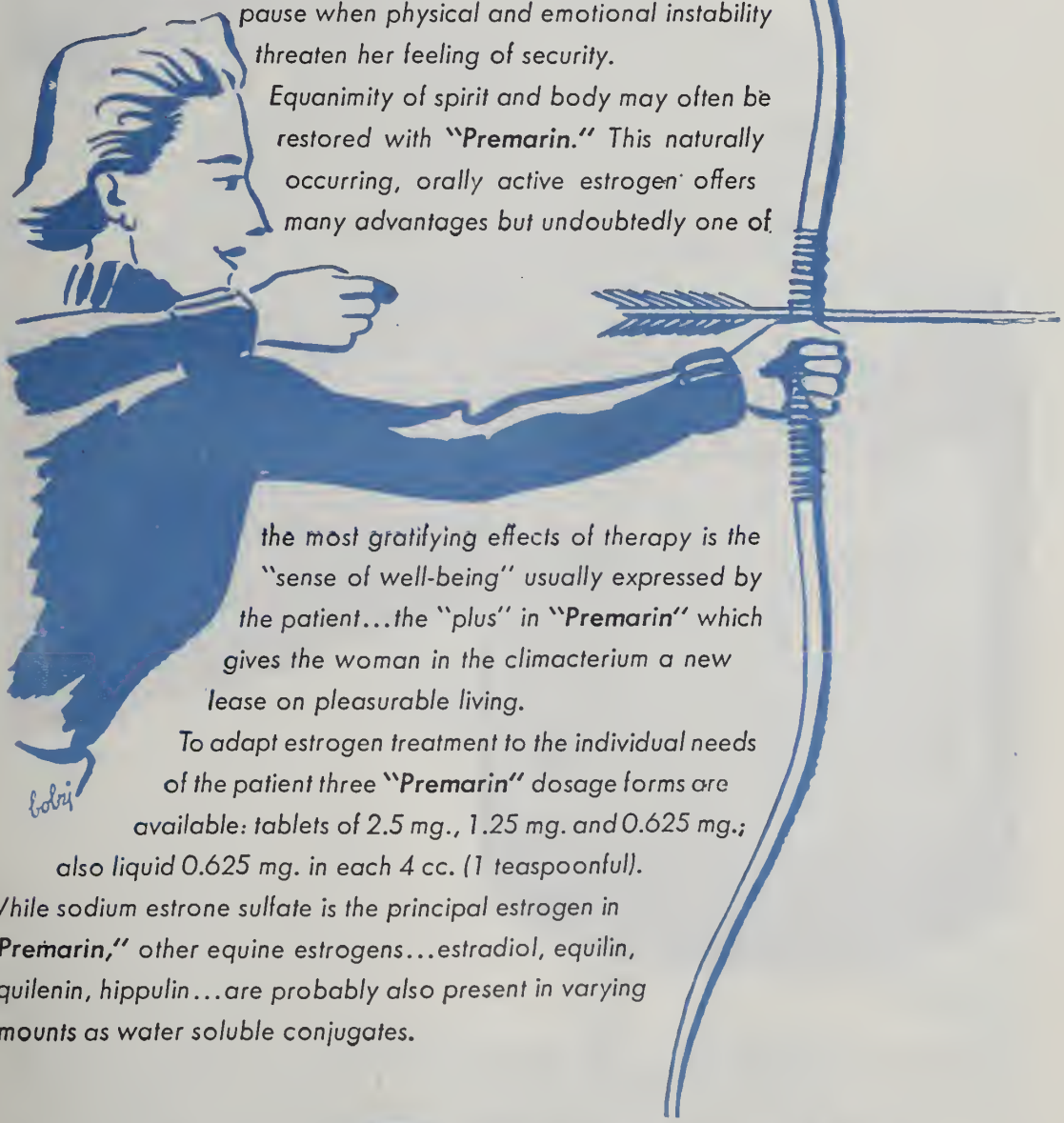
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*Snyder, M. L., Kiehn, C. L. and Christopherson, J. W.: Mil. Surgeon, *97*: 380, 1945. • Shipley, E. R. and Dodd, M. C.: Surg., Gynec. & Obst., *83*: 366, 1947 • Mays, J. L.: J. Med. Assoc. Georgia, *36*: 263, 1947. • Curtis, L.: Surg. Clin. N. America, 1466 (Dec.) 1947.

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.



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PRESIDENT'S MESSAGE

OUR RESPONSIBILITY IN PUBLIC HEALTH

The platform of the American Medical Association, adopted in June 1944, declared that "there is great need for the increase of county or district departments of health . . . . every area in the United States should have a health service with adequate personnel and facilities . . . . it should be integrated with and coordinated by the State Health Department." Subsequently, the American Medical Association has repeatedly urged state and county medical societies to assume leadership in bringing about reorganization and improvement of local health services.

The House of Delegates of The Medical Society of New Jersey adopted a resolution on April 29, 1948, urging enactment of legislation to enable local communities in the fourteen counties of New Jersey below the second class to combine their health services in county or part-county health departments "as an essential step in providing modern, high quality health protection to the people of New Jersey".

The bill now pending in the legislature (S.148) was originally sponsored by the New Jersey Health and Sanitary Association, and is now emphatically supported by nearly every state-wide organization in New Jersey interested in health and welfare.

The principal obstacle to the enactment of this bill seems to be a lack of public information about the need for such legislation and a failure to appreciate its potential benefits, especially in the very counties that stand to gain most by its passage.

The county medical society is properly the physician—and health counsellor—to its community. Therefore, this presents the medical profession with a chal-

lenge. It offers us an opportunity to assume the leadership in educating the people in our communities to the end that they will understand the problem and eventually demand the opportunity to improve their local health services which such legislation alone can provide them.

Our new State Health Commissioner, Dr. Daniel A. Bergsma, pointed out recently that 333 of New Jersey's 566 local health departments are each supported by fewer than 2500 people and 406, (or 72 per cent) of our municipalities have no licensed health officer. Dr. Bergsma has aligned himself clearly in support of the principle of this legislation, and S.148 has been specifically endorsed by the State Public Health Council.

The Medical Society of New Jersey is urging each county society—especially those in counties of the third and fourth class—to study this bill, and to take the initiative in building public interest and support for it. Leadership in this enterprise is clearly a special responsibility of the profession, acting through its county and state societies. It offers us an opportunity to earn public appreciation by demonstrating our concern in the protection and welfare of the people.

J. Howard Hornberger, M.D.
President.

YOU, TOO!

Physicians generally agree that voluntary, non-governmental services are to be preferred to compulsory and government regulated activities. This time of the year sees the launching of the Red Feather campaign which spotlights the role of community, voluntary enterprise. True, our government can do a lot for our welfare, but when it comes to building good communities to live in, that's essentially up to us citizens. In its support of voluntary non-governmental services the Community Chest puts its faith in a good old American ideal: the good community is built not by compulsion but by cooperation; not by selfishness but by sharing.

If somebody suddenly asked you "What is the Community Chest?" you'd probably say, "A group of organizations that help people".

And you'd be right.

But nine chances out of ten you'd be thinking that the people it helps are the "*other* people"—not by any chance you.

And you'd be wrong.

You and your family benefit just as much as the other fellow's family by the presence in this town of hospitals, social agencies, day nurseries, Y.M.'s and Y. W.'s, Scouts—to name only a few familiar Red Feather services.

But even if you or your children never should use one of these services, you still benefit by the Community Chest. And here's how: The Community Chest is a wholesome and democratic force in any man's town. It unites people of all faiths, all political beliefs, all walks of life, to plan and work together for the good of the whole community. It represents the orderly way to plan and raise money for voluntary service. Instead of turning loose on the town 50 separate appeals, it unites them into one campaign, with one big goal to meet many big needs.

The Community Chest allocates the money raised fairly among its member agencies instead of making them compete with each other for public interest and support. It conserves leadership, time and money, cuts administrative costs and thus delivers the maximum value of each dollar raised to the purpose for which it was given.

MEDICAL CARE, SIXTEEN YEARS LATER

Back in 1932, the Committee on the Costs of Medical Care disturbed the self satisfaction of organized medicine by making some recommendations that seemed to be radical to the point of subversion. Actually, what the committee recommended (in its final report, Oct. 31, 1932, *Medical Care for the American People*) was:

"The majority of the committe does not endorse the recommendation which would make health insurance a legal requirement . . . . It is much more desirable to encourage voluntary measures for protection against wage loss during illness and to develop voluntary insurance in conjunction with group practice and hospital service. The difficulties of these plans can be controlled by a combination of professional and community effort. The various pre-payment plans (aside from compulsory insurance) would (1) largely solve the problem of hospital cost, which constitutes 50 per cent of the average family's health expenditures, (2) provide adequately for many rural areas, (3) make better provision than at present for the indigent, and (4) provide through voluntary cooperative insurance, medical service to a majority of the 70 million people in industrial communities and cities."

That certainly sounds conservative enough today, and it seems incredible that sixteen years ago persons who advocated this were suspected of being wild-eyed radicals. This, however, can lead to one of two different conclusions. Either we always lag behind in our social thinking, so that we finally endorse what the rest of the community was accepting a decade or two ago; or the report quoted above represents a basic truth to which our eyes have finally been opened. Some support to the latter conclusion comes from a Brookings Institution report resulting from a study made at the request of New Jersey's Senator H. Alexander Smith. This stresses the great progress in medical and sanitary science made under the voluntary system of medical care, points out that this indicates that the system is free of any serious defects, and recognizes that there *are* people who cannot afford good medical care. It suggests however that compulsory insurance would not help these persons because, by reason of their indigency, they cannot attain an insured status. Compulsory health insurance, says the report "would necessitate a high degree of government regulation and control over the personnel and the agencies providing medical care. The field of regulation would be more difficult than any other field entered by the government. It does not seem probable that politics could be eliminated from medical care supplied under a government system. On the other hand, it seems probable that in many communities, the intelligent cooperation of consumers and practitioners will develop satisfactory arrangements that remain subject to their own control without national government administration."

It is interesting that emphasis was placed on cooperation between the producers and consumers of medical services, back in 1932, and that this facet of the problem has been so casually considered through the years. There have been plans and projects in great profusion, but very little has been done nationally to provide the public with a chance to talk this over at the same table with the doctors and the other health personnel. Our New Jersey Health Congress is one of the few agencies in the nation which does provide such a forum.

ORIGINAL ARTICLES

THE SURGERY OF MALIGNANT DISEASE OF THE LARYNGOPHARYNX*

HENRY B. ORTON, M.D., Newark, N. J.

Herodotus referred to specialties in medicine. Hippocrates,[1] (460-357 B.C.), spoke of the Greek studies in breathing, swallowing and vocalization. Thus it appears that the functions of the epiglottis had interested the ancients. Following Hippocrates, a period of more than 400 years rolled by before laryngology was taken up again in the works of Celsus,[2] (A.D. 14) who mentions tracheotomy as a measure of relief and the first specific description of the technic of this operation was during the reign of Hadrian, (A.D. 117-118).

The surgery of malignant diseases of the laryngopharynx appears to have been known in the earlier times. Boerhave[3] and Morgagni (1668-1738) reported and described the postmortem findings of a case of cancer of the pharynx and larynx in a man of fifty. Trousseau is recorded as having done the first tracheotomy for the relief of cancer of the larynx in 1846. However, it was not until 1854, when Garcia[4] discovered the laryngoscope that our knowledge of laryngeal carcinoma with its accurate diagnosis manifested itself. Desault, over a hundred years ago, appears to be the first surgeon to have performed the operation of laryngofissure. In 1864 Gordon Buck was the first surgeon in America to perform the same operation. Billroth performed the first complete extirpation of the larynx for cancer in 1873. In America, Solis Cohen, in 1877, was the first to remove the larynx completely.

Dr. John MacKenty of New York, whom I greatly admired, did more to develop laryngectomy in this country than any other man, and I have followed many of his procedures. Dr. Fielding O. Lewis of Philadelphia and Dr. Joseph Beck of Chicago, also contributed greatly in developing the treatment of cancer of the larynx by total laryngectomy, while Dr. Chevalier Jackson of Philadelphia developed the procedure of laryngofissure. In England, Sir St. Clair Thomson, Sir Wilfred Trotter and Mr. Lionel Colledge were reporting their successes by laryngofissure, lateral pharyngotomy and laryngectomy, respectively, in the treatment of cancer of the laryngopharynx. It has been my privilege to have known these gentlemen and to have observed their work. I have not accepted entirely the teaching of any one of these surgeons, but my conclusions and procedures are based upon a combination of the knowledge and practical help received from them. Last, but by no means least, I am indebted to Dr. Harris P. Mosher of Boston, for the privilege extended to me in the early years of my work, for the use of his anatomic laboratory in the developing of the ideas best in my judgment, that I learned from the above men. To all of these gentlemen I am deeply indebted, and take this opportunity to pay them tribute.

Since the death of Frederick the Third of Germany, in 1888, a great deal of clinical, pathologic and operative work has been done in carcinoma of the laryngopharynx. We can say, therefore, that real progress has been made in the surgical treatment of malignant disease of the laryngopharynx during the past 50 years. Formerly, the operative mortality varied enormously with the type of operation performed. The operative mortality in thyrotomy was 10 to 20 per cent; 26 to 35 per cent in hemilaryngectomy and 47 to 60 per cent in laryngectomy. This high mortality rate, caused Butlin, in 1887 to say that "results were so gloomy that there seemed to him to be scarcely justification for the performance of a radical operation for cancer in this area. Scarcely a single case had been cured, the mortality extremely high and successes surprisingly small." Such were the results of surgery in malignant disease of the laryngopharynx at the turn of the century. Compare the above with the results at the present time of thyrotomy with 85 to 95 per cent cured and total laryngectomy with 60 to 90 per cent cured depending on the site of the lesion; with an operative mortality rate of 1.9 to 4.3 per cent.

This paper reviews the results of my personal experience with 470 cases of carcinoma of the laryngopharynx in my private practice.

There were 302 operations performed with

*Read by invitation to the Annual Meeting of The Medical Society of New Jersey, April 28, 1948.

1. De Natura deorum Lib. II, Cap. 57.
2. De Natura deorum Lib. II, Cap. 57.
3. Sir St. Clair Thomson, History of The Laryngoscope, *The Laryngoscope*, London, 15:177 (March 1905).
4. Sir St. Clair Thomson, Trans. 17th Internat. Med. Cong., London, 1881, 11:197.

an operative mortality of 1.9 per cent. Three of the six deaths occurred in the first 13 patients. This was rather discouraging. However, there have been no deaths in the last 82 consecutive cases.

More than twenty years ago, Sir Wilfred Trotter said: "What may be our hopes about the discovery in the treatment of malignant disease, of methods more specific and less harsh, surgical operation must be admitted to be the most useful and trustworthy means we now possess". This statement must stand today. The pathologic and clinical principles, combined with the development of surgical technic, have extended the field to which they can be applied. Having chosen a field of surgery which at first sight seems to promise little but narrow technicalities, I hope to show that it has great concern to all of us.

In this series of cases, analyzing the histologic structure of the malignant variety of cancer attacking the laryngopharynx, we find that the squamous cell type predominates. Males predominate in the ratio of 12 to 1. The youngest patient was 13½ years of age and the oldest 76. Since this paper deals only with the surgical treatment, the diagnosis and symptoms will for the most part be omitted.

Limiting ourselves to the laryngopharynx, we are concerned with two groups of cases: first, malignancies within the larynx proper; the epilaryngeal or extrinsic cancer of the larynx, as some term it. Second, malignancies of the lateral and posterior wall of the pharynx, including the post-cricoid area. Lately physicians have developed an increasing interest in the treatment of this disease, yet some have doubts as to the results of treatment by surgery and submit all cases to irradiation. This is especially true of the epilaryngeal type of cancers, and is causing a great deal of controversy as to their treatment. It is true that these extrinsic cancers are insidious in their onset and spread rapidly to the lymph nodes at a very early stage. Some authorities say that the condition is not arrested or cured by surgical operation, and that the patients should be referred to the radiologist for deep x-ray therapy. With this I emphatically disagree. Of the remaining 168 cases, 64 (or 38 per cent), had some form of x-ray therapy and none have lived over three years. Thirty-nine (or 23 per cent) refused operation, many of whom were operable at the time of their first visit. Some physicians even tell their patients, (or the patients believe) that the operation for cancer in this area has a high mortality rate, and that they will lose their voice forever. Such is not the case. Operative mortality in my series was only 1.9 per cent. And a man without his larynx can talk, whistle and smoke again, or even play a musical instrument if he makes up his mind to. This is part of our postoperative care, to rehabilitate the laryngectomized patients in speaking.

Surgical removal means a procedure sufficiently radical to remove the entire primary lesion. The surgical treatment in each case must be governed by the type, extent of the growth and its location. Emotions, economics or conservatism must not be considered. Conservative methods, (such as saving cartilage, muscles or attachments for cosmetic or functional betterment) are unsurgical and unsafe in the treatment of cancer of the laryngopharynx.

Diagnosis can be made early, as the growth is readily seen by direct or indirect examination. Yet I found that 58 of the 168 cases, (34 per cent), were inoperable at the time of my first examination. This is something to think about concerning early diagnosis. Twenty-one per cent needed tracheotomy on the first visit. It is true that cancer cannot be cured in all cases, but certainly if this region is examined with painstaking thoroughness, much can be accomplished by early diagnosis and radical operation. Close cooperation between the pathologist and the surgeon is essential. The biopsy should be taken by the operating surgeon and the pathologist should know from what area the specimen was removed. I, personally, look at all biopsies with the pathologist before operating, and find this cooperation most valuable. New found in his observation on the microscopic extension of the tumor taken at five, ten, and fifteen millimeters from the apparent margin of the growth, that the maximal extension of highly

malignant tumors was fifteen millimeters. This has been brought out by Broyles and Snitman, both of whom have shown that the cancer cells have extended beyond the apparent growth histologically, in the anterior commissural tumors of the cord—an additional reason why the pre-epiglottic space is invaded early, and should be removed with the larynx. This invasion of the pre-epiglottic space, I have demonstrated many times at operations in cancer of the epiglottis below the hyo-epiglottic ligament. This pre-epiglottic space (the space of Boyer) was described by Jean LaRoux in an article published in 1936, and at the same time Tambein demonstrated histologically that cancer of the vestibule and the ventricle of Morgagni, invaded the pre-epiglottic space, and stated that the classical laryngectomy is insufficient for the complete eradication of cancer in these cases. In 1939 at the Academy of Ophthalmology and Otolaryngology I showed a movie of this procedure. Later Clerf brought the subject up again in his paper *The Pre-epiglottic Space—Its Relation to Cancer of the Epiglottis*. The keynote is that we must get away from conservative treatment of cancer of the extrinsic type; we gain nothing by appeasing carcinoma by subperichondrial resection, or narrow field operation.

Surgical procedures in malignancies of the laryngopharynx are (1) thyrotomy or laryngofissure; (2) laryngectomy; (3) laryngopharyngectomy; (4) lateral transthyroid pharyngotomy.

LARYNGOFISSURE OR THYROTOMY

When the growth is on one vocal cord, at the middle third with both extremities of the cord free from disease, and the cord not fixed but retaining its full mobility, thyrotomy is the choice operation. Any fixation of the cord or arytenoid shows muscular involvement, and conservative surgery will be inadequate. In my own experience in properly selected cases for thyrotomy, the results have been 93 per cent living over five years. My first thyrotomy patient, for true cordal cancer of the larynx, is still living 30 years after operation. See Table 1.

LARYNGECTOMY

Indications for this operation are:

(a) When the growth has extended to the anterior commissure, or has extended backwards to the arytenoid cartilage.

(b) The epiglottis is involved below the level of the hyo-epiglottic ligament.

(c) The growth has crossed to the opposite side and there is a subglottic extension.

(d) The growth springing from the ventricle or ventricular fold.

(e) The growth has invaded the thyroid cartilage or the crico-thyroid membrane.

(f) Definite fixation of one or both vocal cords.

(g) The growth is subglottic in origin.

(h) In a recurrence following a laryngofissure operation.

(i) Where the larynx has been subjected to unsuccessful irradiation in selected cases.

To be considered in these cases is the extent of the growth and its location. The growths are usually of squamous type and are readily seen by direct or indirect examination of the larynx. With a growth so situated as above stated, a laryngectomy is the procedure of choice. See Table 2.

LARYNGOPHARYNGECTOMY

The surgical treatment for the epilaryngeal group or extrinsic type of cancer is more difficult, since the entire larynx with some of the pharyngeal tissue must, according to the site of tumor, be removed along with the larynx, with the possible exception of cancer of the epiglottis, on the laryngeal surface, above the level of the hyo-epiglottic ligament. In such a case, the upper part of the epiglottis can be removed by a lateral transthyroid pharyngotomy, with excellent prospects of a lasting cure. See Table 2.

TABLE 1

LARYNGOFISSURE OR THYROTOMY

	14		
Alive and well	9	Alive and well under one year	2
Died from recurrence	1	Alive and well one to five years	1
Died from other causes	4	Alive and well ten to thirty years	6
	14		9

Successful cases 9 plus 4, total 13 or 93 per cent cures.

THE EPIGLOTTIS

Some authorities say that a cancer on the edge, or on the laryngeal surface of the epiglottis, may be approached by a lateral pharyngotomy and the epiglottis excised, so as to leave the main structure of the larynx intact. I qualify that by saying that the growth on the epiglottis must be above the level of the hyo-epiglottic ligament since early invasion of the pre-epiglottic space is certain to take place with any growth below this level. I strongly recommend that with any growth of the epiglottis below the level of the hyo-epiglottic ligament, the epiglottis with the larynx and hyoid bone should be removed *in toto*. This seems radical, but radical we must be if success is our goal. Any growth above the level of the hyo-epiglottic ligament may be removed by lateral pharyngotomy.

THE ARYEPIGLOTTIC FOLDS

If seen very early, cancer in this region may be removed by lateral pharyngotomy, but usually by the time the patients present themselves for operation, the growth has already extended beyond the area for this type of operation; then we must resort to a wide excision of the larynx with the hyoid bone and pre-epiglottic space and perhaps some of the lateral wall of the pharynx.

The Pyriform Sinus. Here the tumor infiltrates both the outer and inner walls of the sinus which is so closely connected with the larynx, that nothing short of a complete laryngectomy with the hyoid bone and pre-epiglottic space would be of any avail. Even a node resection may be necessary in conjunction with this procedure.

The Lateral Walls of the Pharynx. A cancer here can be removed by lateral pharyngotomy, preceded by a node dissection at the time of operation, preferably, and followed by a plastic reconstruction at a later date if necessary.

The Post Cricoid. If seen very early, a lateral pharyngotomy with plastic reconstruction following at a later date may be done, but if the cord is fixed, and the cancer has advanced, nothing but a laryngopharyngectomy is of any use.

Lateral pharyngotomy is an ideal operation for inspection and removal of cancer of the lateral wall of the pharynx. It has, however, its limitations. It is like the laryngofissure operation in intrinsic cancer of the larynx. Lateral pharyngotomy is only for very early cases of extrinsic cancer of the lateral and posterior wall of the pharynx, and the epiglottis as mentioned above. Complete destruction of all cancer cells is, at present, the only known method of effecting a permanent cure, whether this be by surgery, irradiation or by some biologic change in our makeup. See Table 3.

RESULTS

At present, two conclusions present themselves. First, we have technical methods which seem soundly established and capable of progressive refinement and extension. Second, in cases carefully, but not too rigorously selected as favorable, we can look for satisfactory results as to the disease, cures by drastic but not very dangerous operations which have no serious disability. I cannot agree with the statement that these operations

TABLE 2

LARYNGECTOMIES AND LARYNGOPHARYNGECTOMIES

220

Alive and well	118	Alive and well under one year	21
Died within 3 weeks of operation	6	Alive and well one to five years	29
Died from recurrence	54	Alive and well five to ten years	31
Died from other causes	42	Alive and well ten years and over	37
Lived under five years	17		118
Lived over five years	25		
	220		

Successful cases 118 plus 42, total 160 or 72.7 per cent cures.

TABLE 3

PHARYNGOTOMIES

17

Alive and well	4	Alive and well five to ten years	2
Died from recurrence	6	Alive and well ten to fifteen years	2
Died from other causes	7		4
	17		

Successful cases 4 plus 7, total 11 or 65 per cent cures.

TABLE 4

COMBINED RECAPITULATION

251 MAJOR OPERATIONS NOT INCLUDING 51 TRACHEOTOMIES

OPERATIVE MORTALITY 1.9 PER CENT

Alive and well under one year	27	Died from other causes who lived under one year	20
Alive and well one to five years	42	Lived from one to five years	9
Alive and well five to ten years	25	Lived from five to ten years	9
Alive and well over ten years	37	Lived ten years and over	15
	131		53

Alive and well 131
Died from other causes 53

Successful cases ..... 184 or 73 per cent cures.

TABLE 5

EXTRINSIC CANCER OF THE LARYNX

140 cases of extrinsic cancer of the larynx and pharynx operated on or given some form of irradiation showing results by years.

	Radiation						Surgery					
		Years						Years				
Site of Cancer	*No.*	*1*	*2*	*3*	*4*	*5*	*No.*	*1*	*2*	*3*	*4*	*5*
Epiglottis	9	7	1	0	1	0	12	3	1	1	2	5
Epiglottic Fold	11	9	2	0	0	0	13	7	3	1	0	2
Arytenoid	7	5	2	0	0	0	6	2	1	1	0	2
Pyriform Sinus	25	22	3	0	0	0	20	8	6	1	0	5
	52	43	8	0	1	0	51	20	11	4	2	14

	Radiation 3 Years and Over 1 Surgery 3 Years and Over 39%						Over Five Years 0 Over Five Years 27%					
Post Cricoid	8	8	0	0	0	0	16	10	4	0	0	2
Lateral Wall Pharynx	0	0	0	0	0	0	13	6	2	2	1	2

are mutilating. In our follow-up we rehabilitate the laryngectomized patient in the use of the esophageal or pharyngeal voice. It is gratifying to see how very promptly these patients readjust themselves, returning to their former occupations and enjoying life. See Table 4.

The preoperative and postoperative care of these patients is of the utmost importance. It is only with the meticulous care and the coordinated efforts of the surgeon, pathologist, anesthetist, assistants and nurses that it is possible to show the results as I have. These operations are not one man's work. They involve team work of the highest type and it is with this team work that we are able to have the low mortality rate.

Radical surgery saves many lives that would have been sacrificed if more conservative forms of surgery had been performed, and more lives can be saved by surgery if diagnosis is made earlier in the epilaryngeal or extrinsic cancer of the laryngopharynx. See Table 5.

224 Delavan Avenue

CALLING ALL PEDIATRICIANS

All physicians interested in children are invited to participate in a unique conference sponsored by the New Jersey Fellows of the American Academy of Pediatrics.

Date: Wednesday, October 6, 1948.

Time: Sessions at 9 a. m. and at 2 p. m. See program below.

Place: Mercer Hospital, 444 Bellevue Avenue, Trenton.

Morning Program starts at 9 a. m. with papers on (1) Hepatitis, (2) Multiple hemorrhagic hematomata, (3) Lymphatic leukemia without leukemia, (4) Measles and, (5) Ulcerative colitis of the New-Born.

Luncheon will be served at the Mercer Hospital at 1 p. m. Physicians wishing to join in this luncheon will notify Dr. Blaugrund by October first. Dr. Blaugrund's address is 833 West State St., Trenton 8, N. J.

Afternoon Program is devoted to Behavior Problems. This opens at 2 p. m. with a discussion of the general home philosophy as the emotional climate for preschool children. The role of the school is then reviewed and the position of the pediatrician and family doctor in moulding personality will be the third topic for discussion.

Speakers: The all-star program includes the following speakers: Doctors Ralph Tyson, Harold Davis, Samuel Blaugrund, Thomas Rathmel, William Little, Paul Mains, Edward Duffy, Bruce Robinson, and George S. Stevenson.

For detailed program, write to—

DR. ARTHUR HEYMAN
89 Lincoln Park, Newark 5, N. J.

or to

DR. SAMUEL BLAUGRUND
833 W. State Street, Trenton 8, N. J.

No business firm would send out a bill, often for hundreds of dollars, labeled simply "For Merchandise". Yet the physician commonly does this, in sending out bills labeled only "For Professional Services".—"Disease and the Man"—Lapham.

Doctors who need to have scientific articles translated from Chinese or Japanese can secure this service through the American Documentation Institute at 2101 Constitution Ave., Washington, D. C.

MANAGEMENT OF PRURITUS ANI *

Irving G. Larkey, M.D., Newark, N. J.

All persons at one time or other, because of poor rectal hygiene, excessive perspiration, overindulgence in spicy foods, or other reasons, will experience anal itching. This is usually transient and involves no skin changes. We are concerned, however, about cases in which a change from the normal can be seen in the anal and perianal skin, and those in which the victim is annoyed or tormented by that unrelenting itching sensation that begs for relief.

Pruritus ani is a symptom-complex often found in high-tensioned individuals, more frequently in men, characterized by an overwhelming itching sensation in and about the anal region, turning to a burning type of pain when excoriations and/or fissures develop. It becomes worse when the body is at rest or during and immediately following defecation, and is frequently associated with a pruritus scroti or vulvae. The "typical" pruritus lesions consist of a whitened, thickened, edematous anal skin with accentuation of the rugae, radial fissuring, excoriations and superficial ulcerations. In most cases the area is moist and oozing. The tendency is for extension both posteriorly along the intergluteal fold, and anteriorly along the median raphe. Not infrequently the process is confined to the intergluteal fold, not reaching the anal verge; but I have never seen a case in which the anterior median raphe was alone involved.

Many persons suffer with pruritus ani and learn to live with it. At least they do not seek medical aid, but rather buy the well-advertised patent medications and proprietaries for relief. It is only when the symptoms become severe or unbearable that such people see their doctors. Unfortunately, many practitioners pass off this complaint as a "minor" ailment and usually prescribe some suppository antifungicide or anesthetic ointment. It seems true that no matter what is done for these cases there is likely to be either a remission or at least some temporary improvement. Many dermatologists use x-ray therapy, and in some cases with good results. However, if you see many cases, you will find a goodly number who have been through one or more series of such treatments with recurrences, and occasionally with permanent skin damage from overzealous therapy. Certainly that is not the answer.

Operative procedures have been devised for the "cure" of this ailment. The Ball undercutting operation and its many variations have their proponents, as do the tattooing technics and the injection of various strengths of alcohol and hydrochloric acid solutions. These are all successful to a degree, but certainly not uniformly. But here we have major procedures with their attendant risks. It usually calls for hospitalization and more than local anesthesia. Patients who are subjected to injections of alcohol or hydrochloric acid solutions sometimes have sloughing. These patients theoretically, have a better chance for cure than those who do not slough; yet too often they get a return of itching just about the time the sloughs have healed. Patients subjected to tatooing, also, after a period of relief, get a return of edema and fissuring along with the attendant symptoms. And what of those victims of the Ball operation; do they fare any better?

We know no more about the cause than was known 30 years ago. One has only to peruse the old literature on the subject to find that the same theories are re-discovered and rehashed from time to time.

Unquestionably certain cases of pruritus ani, usually atypical in appearance, can be shown to be due to a definite causative agent. No case is properly managed if fungus infection, worms, allergies, etc., have not been ruled out. With these types, specific therapy is indicated.

A fair proportion of cases have their beginnings in some infectious or irritative lesion within or about the anus in which a mucoid or purulent discharge is continually in contact with the skin over a period of at least several weeks.

* Read before the New Jersey Proctologic Society on January 9, 1948.

Well substantiated cases of pruritus ani have begun soon after surgery for anal fissure, hemorrhoids or other ano-rectal pathology in which an open draining wound had been, of necessity, left to heal by second intention. But I believe that there has to be a certain degree of individual susceptibility to the development of this condition. Despite this, oddly enough, most patients exhibit remarkably little ano-rectal pathology aside from the pruritic changes. Certainly this is not in keeping with the preconceived idea of the importance of fissure, fistula, prolapsing hemorrhoids, etc., in this condition. However, it is generally agreed that such complicating pathology, when found, may be a factor in keeping the process active, and should be corrected.

The surgical removal of such foci of infection will, by itself, never cure the pruritus. Often a patient says that a doctor told him that his itching was due to some skin tag or to hemorrhoids. He has then subjected himself to operation. Yet without medical management thereafter no cure has occurred; in fact, the condition may have become worse.

Some writers suggest that in the well established case there are no internal hemorrhoids present because of the stiffening action of the process extending up into the anal canal and lower rectum. This, I have found to be untrue except in the unusual case. I have treated patients with a pruritic history of from two to five years in whom the lower rectal mucosa was completely uninvolved. Instead, they presented a flabby redundant mucosa with or without hemorrhoids. The longest duration in my records is that of a 58 year old man with a history of perianal and anal itching for 40 years. Besides having total distortion of the anal skin, marked by hypertrophied folds, puckerings, and deep sulci, he had the typical whitened and fibrotic skin of the old established case. He also had redundancy of the rectal mucosa and moderate non-prolapsing internal hemorrhoids.

Every case of old well established pruritus ani that I recall seeing had undergone complete or nearly complete obliteration of the external hemorrhoidal venous plexus through fibrosis.

The condition is a vicious cycle. Once the cycle has been interrupted, symptoms are more easily controlled. In a case which has once been arrested, should symptoms return through neglect, it can more easily and rapidly be controlled than the first time.

In most cases, results of treatment are very soon apparent. Almost immediately the itching decreases in frequency and degree. The whiteness of the skin disappears, the excoriations and fissures heal, the area becomes dry, the edema subsides, the skin folds flatten out and become softer and more flexible. Even those in which, at first, there appears to be permanently thickened skin and fibrosis soon may become normal or practically normal in appearance. In some cases for the next several weeks one or more superficial ulcerations may reappear and be accompanied by some return of itching, but I have found that this occurs chiefly in patients who have "cheated a bit" on the routine. So long as the patient exercises due care and consideration he will usually get along very nicely. Most of the "conservative" treatment is performed by the patient at his home. The more conscientiously the routine is followed, the happier the results. It is very discouraging to have a patient improve one week and relapse the next. Questioning will usually elicit the fact that he began to neglect himself almost as soon as he was relieved; or that he was too busy with other things to spend the necessary few minutes required.

Here is an outline of the routine which I follow:

PROFESSIONAL MEASURES

1. A history, paying particular attention to possible allergies, worms, rectal and lower pelvic disorders.

2. A complete proctologic examination.

3. Correction of ano-rectal disease soon after management is begun.

4. Patients who show mild to moderate internal hemorrhoids, (or even only a redundancy of the rectal mucosa) are given sclerosing injection therapy. The rationale for this is relief of rectal congestion.

5. At each office visit, the involved area

is painted with silver nitrate solution followed by gentian violet, or with a saturated solution of potassium permanganate. I have found the permanganate to be equally as effective and much less messy.

HOME MEASURES

1. Rectal hygiene includes proper cleansing, without rubbing after defecation, by the use of wet cotton. The area is then dried by patting with soft tissue and powdered with cornstarch or boric acid powder. Similar measures are used after bathing. Rectal hygiene is the most important single measure in the management of this condition.

2. Constipation, if present, is treated by the use of smooth bulk laxatives rather than by the oily laxatives. This is to prevent the leakage of oil and consequent soiling of the anal skin.

3. The patient is required to avoid all spicy foods and alcoholic beverages. These substances frequently cause an irritating stool with consequent irritation of the anus and surrounding tissues.

4. The use of a drying and healing ointment consisting of phenol, ichthyol and coal tar (in a suitable base) once or twice a day. This is a useful adjunct in clearing up the condition. In severe cases, it is better to start with compresses of dilute Burow's solution or a solution of Linit starch applied several times a day for a few days, until the acute reaction has subsided.

All instructions are written so that nothing can be forgotten or left to the imagination.

95 Shanley Avenue

STREPTOMYCIN AND TINNITUS

When large doses of streptomycin are given daily, a continuous low-pitched roaring sound in both ears may signal the start of low-tone nerve deafness. To prevent loss of hearing, therapy should be stopped or reduced. Dizziness or lightheadedness was noted by Brown and Hinshaw of the Mayo Clinic. Inability to walk a straight chalk line was an early indication of toxicity. Hearing was lost by five patients taking 10 Gm. of streptomycin. In no case was cochlear function disturbed by 2 Gm. daily.—*Proc. Staff Meet., Mayo Clin. 21:347.*

ALLERGY IN WOUND INFECTION

Food allergy should be considered as a possible cause of delayed healing in wounds of the abdomen. Delayed healing and continued discharge should be explained by an Auer reaction in the tissues of the wound or by impaired production of fibroblasts. The first such case ever reported was encountered by Rowe in a boy with a refractory abdominal wound associated with recurrent serosanguineous discharge for two years. A lifelong gastro-intestinal allergy was relieved and rapid closure and cessation of discharge followed within three weeks of the institution of a cereal-and-fruit-free elimination diet.—*West. J. Surg. 54:313.*

CHOLECYSTITIS

Early cholecystectomy may be lifesaving in acute cholecystitis. Because of the hazard of perforation and peritonitis, the patient should be operated on as soon as prepared. Mortality increases with delay. Analysis of 12,000 consecutive necropsies by Johnstone revealed 32 instances of perforation of the gall bladder. Unrecognized cholecystitis in 49 per cent progressed to perforation and death. In 105 other patients operated on within forty-eight hours, mortality was 2.9 per cent.—*Arch. Surg. 53:1.*

PENICILLIN FOR OTITIS MEDIA

Uncomplicated acute suppurative otitis media usually clears after instillation of penicillin drops. The treatment is free of the dangers of sulfonamide medication. In 15 of 19 patients treated by Loeb, involved ears became dry within five days; in the other four patients treatment had to be continued from ten to thirty days. A solution of penicillin salt in isotonic saline, 1000 Oxford units per cubic centimeter, is used. The drops are instilled three times daily. After each instillation a cotton wick is placed within the aural canal. Penicillin drops used alone are not effective in long-standing chronic suppuration.—*Arch. Otolaryng. 43:586.*

THE PHILOSOPHY AND MEANING OF THE REORGANIZATION PLAN FOR THE STATE DEPARTMENT OF HEALTH

Daniel Bergsma, M.D., M.P.H., State Commissioner of Health, Trenton, N. J.

The preamble to the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". I subscribe to this concept. The basic concept of public health has been changing from one of prevention of disease only to that of increasing the good health of the community. This change in concept places a heavy premium on a community organization and a health education program which will call for greater leadership from organized public health and for greater cooperation from all participating citizens.

Consolidation and integration of functionally related activities should be carried out so as to yield optimum effectiveness and efficiency.

The best way to accomplish effective results in any program is to select an individual who has all the desirable academic background and appropriate experience, plus suitable personality and to give him all the necessary authority, facilities and privileges to carry out effectively the specifically defined program.

With these concepts in mind, I have completed a reorganization plan for the State Department of Health of New Jersey which I have been developing over a period of years and which was unanimously approved by the Public Health Council when I recommended it to them on June 7, 1948.

It is my purpose in this paper to outline the reorganization plan and tell how I propose that it should work. The plan does *not* envision the mere splitting of a previous bureau to create two bureaus or the consolidation of two bureaus to create one. The plan *does* envision administrative alignment and grouping of all functionally related activities into a given bureau under the control, administrative supervision and leadership of a Bureau Director who is eminently well qualified for the specific responsibility involved. On the basis of this functional division of responsibility I have proposed six major bureaus.

DISEASE PREVENTION

The total problem of keeping specific diseases away from human beings may be divided into two major categories. One involves all of the indirect or non-personal efforts, such as the control of water supplies, sewage disposal, stream pollution, food and drugs, diseases of animals and fowl which are transmissible to men, insect and rodent control, poisonous plant control, etc. These are activities conducted in the environment of man, designed to prevent illness from reaching man. This functionally related group of activities will be conducted within a *Bureau of Environmental Sanitation.*

The second major aspect of the problem involves the more direct or personal approach. The objective is the same and the activities are interrelated and on occasion must be coordinated, but the types of professional skills and judgment, or the technics involved, are sufficiently different to justify clearly a *Bureau of Preventable Diseases,* which involves immunization against certain diseases, early diagnosis and rapid treatment, and/or isolation of infected persons to prevent the further spread of such diseases. This involves research into the epidemiology and the search for the infecting agents in some diseases. The Bureau of Preventable Diseases will concern itself with developing plans for the control of the acute communicable diseases, venereal diseases, tuberculosis, cancer and malignant diseases and dental diseases.

LABORATORY SERVICES

The third bureau is a new one, with a new name. It is the *Bureau of Constructive Health* The Director of this bureau will be specifically responsible for the development of effective, practical plans which can be applied at the local level to increase the good health of the community.

It is obvious that a good water supply can be made available without expecting each citizen who benefits from it to take an active, consciously cooperative part in the program. How-

ever, in the field of nutrition, for example, a much greater degree of public health education is necessary and a high degree of individual acceptance and participation is required to achieve results. A much more effective, aggressive program to enhance the relative health of all our citizens can be achieved by making this great task the sole responsibility of a major bureau headed by a highly competent, full-time director. The Bureau of Constructive Health will, at the state level, include all activities in the field of nutrition, public health nursing, maternal health, child health, adult health and mental health.

The three bureaus enumerated above require a great volume of highly specialized and varied laboratory procedures. Accordingly, a *Bureau of Laboratories* is provided to render such services and also to provide certain direct services to practicing physicians in our state. This bureau would conduct activities involving bacteriology, parasitology, virology, serology, chemistry and pathology.

LOCAL HEALTH SERVICES

The proper coordination of state and local health department activities is a very important specialized and full-time task. Every state department of health provides itself with a Bureau of Local Health Services for this purpose. Our plan envisions the performance of health surveys and evaluation studies throughout the state so that relative weaknesses and strengths may be known, wasteful overlapping eliminated and the health voids properly filled insofar as efficient management of available funds and personnel permit. This *Bureau of Local Health Services* would control subsidies to local health departments, operate state district health offices and have primary responsibility for official contacts between the whole State Department of Health and the functioning local health departments.

The sixth bureau is primarily a service agency to the other five. It has an undesirably long title, which at present is legally unavoidable. It is called the *Bureau of Vital Statistics and Administration.* It will receive and be responsible for vital records, reports of disease, and statistical research. This bureau will manage all general supplies, printing, etc. It will make all inventories and cost analyses. It will keep all finance and personnel records. This bureau will be designed to conduct highly technical statistical research in all public health matters and will administer all business matters for the entire department in a manner designed to free the professional staff for full-time service which demands their professional knowledge and judgment and for which they will be paid.

The minimum qualifications for Bureau Directors, Department of Health of New Jersey for the six bureaus described herein are summarized below.

MINIMUM QUALIFICATIONS FOR BUREAU DIRECTORS,
STATE DEPARTMENT OF HEALTH OF NEW JERSEY

	Academic Degrees and Proficiency Requirements	*Previous Full-time Acceptable Successful Experience*
BUREAU OF ENVIRONMENTAL SANITATION	B. Eng. or equivalent plus M.P.H. or M. San. Eng. or equivalent.	Ten years in public health engineering with considerable administrative and/or supervisory work; 5 years of which may have been teaching sanitary engineering.
BUREAU OF PREVENTABLE DISEASES	M.D., M.P.H.	Five years of public health with considerable administrative and/or supervising work.
BUREAU OF CONSTRUCTIVE HEALTH	M.D., with: M.P.H. or D.Ed., or Diplomate American Board of Pediatrics.	Five years of public health with considerable administrative and/or supervising work.
BUREAU OF LABORATORIES	M.D. plus a Diplomate of the American Board of Pathology, Certified in Clinical Pathology *and* Pathologic Anatomy.	Five years as director or assistant director of clinical laboratory of suitable size; 2 years of which may have been in teaching appropriate subjects at post-college level.

BUREAU OF LOCAL HEALTH SERVICES	
M.D., M.P.H.	Ten years of public health with considerable administrative and/or supervisory work; 2 years of which must have been director or assistant director of a state local health service program or equivalent.
BUREAU OF VITAL STATISTICS AND ADMINISTRATION	
M.D., and M.P.H. or Ph.D. in Statistics or Sociology.	Ten years teaching statistics including public health statistics or doing public health statistics or equivalent.

Each Bureau Director must hold or be eligible to obtain promptly the appropriate New Jersey license.

Each appointee must possess the qualities of personality and character necessary to insure successful prosecution of the scientific and administrative duties. These include such qualities as leadership, the ability to establish and maintain favorable relations with the public and his own personnel, creative ability, far sighted sound judgment and common sense, and the will to serve honestly and industriously at all times, subordinating his own desires to the best interests of the community.

ARE YOU PRESENTING A SCIENTIFIC EXHIBIT?

Now is the time to file for space in the gallery of scientific exhibits for the 1949 Annual Meeting of The Medical Society. Since more applications are usually received than there is space available, it will be necessary to follow a policy of "first come, first served". To obtain an application blank, ask the pathologist at your hospital, or write to the undersigned. Completed application forms should be sent to:

ASHER YAGUDA, M.D.
61 Lincoln Park, Newark 2, N. J.

COUNTY SOCIETY MEETING DATES

1948—1949

County	1948 Sept.	Oct.	Nov.	Dec.	1949 Jan.	Feb.	Mar.	Apr.	May	June	July
Atlantic (Fri.)	11	8	12	10	14	11	11	8	13*	..	..
Bergen (Tues.)	14	12	9	14	11	8	8	12	10*	14	..
Burlington (Thurs.)	9	14	11	9	13	10	10	14	12*	..	..
Camden (Tues.)	..	5	2	7	4	1	1	5	3*	..	..
Cape May (Tues.)	..	26	23	28	25	22	22	26	24*	..	..
Cumberland (Tues.)	..	12	..	14	..	8	..	12*	..	14	..
Essex (Thurs.)	..	14	11	9	13	10	10	14	12*	..	..
Gloucester (Thurs.)	16	21	18	16	20	17	17	21	19*	..	..
Hudson (Tues.)	..	5	2	7	4	1	1	5	3*	..	..
Hunterdon (Tues.)	..	26	..	..	25	..	..	26*	..	..	26
Mercer (Wed.)	..	13	10	8*	12	9	9	13	11	8	..
Middlesex (Wed.)	..	20	17	15*	19	16	16	20	18	15	..
Monmouth (Wed.)	22	27	24	22	26	23	23	27*	25	22	..
Morris (Thurs.)	..	21	..	16	..	..	17	..	..	16*	..
Ocean (Wed.)	8	13	10	8	12	9	9	13	11*	8	..
Passaic (Tues.)	21	19	16	21	18	15	15	19	17*	..	..
Salem (Fri.)	17	15	19	17	21	18	18	15*	20	..	..
Somerset (Thurs.)	..	14	11	9	13	10	10	14	12	9*	..
Sussex	Sept., Dec., Feb.—time and place designated by President.										
Union (Wed.)	8	..	10	..	12	..	9	13*	11	..	..
Warren (Tues.)	..	19*	..	..	18	..	..	19	..	..	19

* Annual Meeting

UNUSUAL NAIL SHEDDING DUE TO NAIL POLISH BASE COAT

IRVING SHAPIRO, M.D., Newark, N. J.

The writer recently was consulted by a number of women with complaints of nail injury. All have been longtime (10 to 20 years) users of nail polishes. The single factor unique in each case was the use of a relatively new rubber-resin base coat. This is applied to the nails before the top coat of nail polish. Better adhering, anti-chip and wearing qualities are said to result. Length of use varied from one to thirteen weeks.

Patch tests with nail polish, base coat, and solutions of the rubber and resins in the base coat were applied to the arms and thighs of the patients who varied in age from 30 to 60 years. All reacted strongly to either the base coat or rubber or resin components of the base coat. None reported allergic backgrounds.

Histories in all cases were similar. The nails began to appear discolored, a variable amount of pain in the free end of the nail occurred, and then the nail lifted away from its attachment to a greater or less degree. Frequently all nails were involved, sometimes only four or five on both hands. In several cases, the nail bed and matrix were only chronically irritated by the base coat, resulting in hypertrophy and the production of warty thickening of the nail bed and lifting away of the nail. None of these cases has recovered completely. Detection of the cause and its elimination have arrested the condition.

Treatment with x-rays and salves in some cases, (and no care in others), has resulted in no remarkable difference in the involved nails. As they grow out at the rate of about three millimeters per month, the new nails are usually normally attached, firm, and of good quality.

CASE REPORTS

1. A forty-eight year old, white, married woman, used nail polish for many years. Her health has always been excellent; she denies any allergies and is not taking any medicine. One month after using nail polish base coat, she noticed brownish red streaks in all nails followed by gradual lifting away from the bed starting from the free end. Patch test was 4 plus in 24 hours on back to nail polish base coat only.

2. A thirty-year old, white, married female denies allergies and has always been in good health. She has used nail polish for the previous twelve years without complaint. Three months after application of nail polish base coat she noticed red streaking of all nails and a gradual lifting from the nail bed. All nails felt painful for a time. This has subsided but the nails have remained partly unattached and disagreeably weak. A dark black membrane has appeared under the free end of most nails. Patch test was 4 plus in 48 hours to nail polish base coat, and 4 plus in 48 hours to rubber component in base coat.

3. A sixty-year old white widow, who has always been in good health denies any allergies, takes no drugs and had no nail trouble until a week after first application of nail polish base coat. Suddenly all the finger nails began to swell, ooze, and become painful. When the inflammation subsided with wet dressings, all the nails began to lift off their beds. Months later the nails were still partly attached. There is a thick horny dark membrane under the free edge of most nails. Patch tests were 4 plus in 24 hours to nail polish base coat only.

Several other similar cases were observed. Their stories coincided with the first three in that:

1. Nail polish employed for many years.
2. No allergies present.
3. General health excellent.
4. One week to three months after the application of base coat the finger nails showed brown red streaking and gradually appeared to lift away from the nail bed. In some cases the nail bed appeared thickened and horny, almost wart-like due to chronic irritation.
5. Patch test reactions were 4 plus in 24 to 48 hours to base coat or its components when applied to arm, leg, or back.
6. No distant eruptions were seen due to covering the base coat with the top plastic layer of nail polish.

CONCLUSIONS

1. A nail polish base coat is described as a new cause for the shedding of nails.

2. A single popular proprietary base coat is implicated in all cases.

3. Patch tests suggest a specific sensitization to base coat or its components. Endocrine or systemic disease does not appear to be a factor.

4. Treatment is directed at removal of the cause and palliative measures.

78 Clinton Avenue

INFECTIOUS HEPATITIS *

Albert G. Markel, M.D., Paterson, N. J.

In the recent war, epidemic hepatitis was a medical problem of the first order, often second in importance only to malaria and venereal disease. This is scarcely surprising, when one considers the roles played by:

1. War; the crowding, poor sanitation, and fatigue.
2. Famine; with the effect of malnutrition on the liver.
3. Pestilence; the reduction of the resistance of the liver, incident to other infections.

For many years, jaundice was referred to as catarrhal in character. However, during World War I, the livers of four soldiers, killed in action, who were suffering from catarrhal jaundice, were studied by Eppinger, and in each instance, the papillae of Vater, and the bile ducts, appeared normal, but the liver exhibited the histologic picture of an acute destructive jaundice.

During the recent war, epidemic jaundice occurred in all parts of the world. Thus, in the construction of the Alcan Highway, our civilization was brought to the Canadian and Alaskan Indians, with it the penalties of disease, which included influenza, typhoid fever, and epidemic jaundice. Apparently the infection was carried by healthy carriers. Transmission of icterogenic agents to healthy persons, occurred through the administration of pooled serum, or plasma; or products containing one or the other, as for example, yellow fever vaccine. This was termed "homologous serum jaundice" regardless of whether the source was yellow fever vaccine, measles or mumps convalescent serum; or whole blood or plasma transfusions. The incubation period in this type of jaundice was prolonged, as long as two or three months, actually twice as long as in the spontaneous form.

In New Guinea, the south and central Pacific, in the North African campaign, and in the Mediterranean theatre, epidemics of jaundice occurred. The incubation period was 30 to 40 days. Many who were sick did not have jaundice; it was a generalized infection, with fever, backache, grippe; the liver was tender and enlarged, and there was a generalized lymphadenopathy. Thereafter, the acute symptoms subsided, and in a week or two the jaundice appeared. A slight leucopenia was present at times. Liver biopsies and nasal washings from these patients, were returned in 24 hours by plane to the United States. Here, conscientious objectors, were innoculated with the washings, and the disease induced and transmitted.

In 1943, in the Poconos, 400 cases of jaundice were studied; the source was virus contaminated well-water. Washings from the stool specimens of patients, when fed and innoculated to conscientious objectors, produced this disease.

It was thought that homologous serum jaundice was due to one type of virus, with a long incubation period, and no stool infection; whereas, in acute infectious hepatitis, the virus is contained in the gastro-intestinal tract.

An epidemic of jaundice at a copper plant in Yonkers in 1943, very nearly brought the Germans to victory, since here was made the apparatus to counteract the enemy's magnetic mines.

In the Italian campaign, when troops were badly needed, the army rounded up convalescents from this disease, and trucked them to the front. Many had relapses, and were sent back. Many died, and autopsies disclosed subacute yellow atrophy of the liver. At this point it was realized that a prolonged convalescence was imperative.

In England, an epidemic of jaundice occurred in a diabetic clinic, where insulin syringes were not boiled. No jaundice occurred, when the needles were sterilized.

Watson[1] describes three functioning units of the liver: (1) hepato-cellular, (2) cholangiolar, (3) reticuloendothelial. The available laboratory procedures permit one to gain information about the first two. While the Kupfer cells of the liver are often seriously

* Delivered at the Fall Conference; The Medical Society of New Jersey, Paterson, N. J., Oct. 29th, 1947.

1. Watson, C. J., and Hoffbauer, F. W.: Annals of Internal Medicine, 25:195 (1946).

effected in hepatitis, there is at present no means to determine their degree of injury.

The term "cholangiolar", refers to the intermediary portion of the intrahepatic biliary tract, including the ampulla of the bile capillaries, at the periphery of the liver lobule.

THE VAN DEN BERGH TEST

Bilirubin combines with Ehrlich's diazo reagent, in alcoholic solution, to form acetophenolazorubin. This reaction requiring the use of the alcoholic solution is termed the "indirect reaction" and is specific for bilirubin.

The direct mixture of serum and reagent, in an aqueous acid solution constitutes the "direct reaction".

The bilirubin of normal serum, and that resulting from hydrolysis of hemoglobin, gives only the indirect reaction; while bilirubin of the bile gives both indirect and direct reactions. Therefore, some change occurs in the bilirubin molecule, during its passage through the hepatic cells from the blood to the bile.

The production of a positive direct reaction in the blood serum implies that the bilirubin has reentered the circulation, after having passed out of the blood, through the hepatic cells, and into the bile cannaliculi; as seen in biliary obstruction or hepatocellular damage.

The three types of direct reactions are: (1) immediate direct, (2) biphasic direct, (3) delayed direct. The appearance of the characteristic color in aqueous solution, within 60 seconds is a "positive direct" reaction; the absence of color development is a "negative direct" reaction.

Bilirubin in the serum that gives a negative direct reaction, has not passed through the hepatic cells, and if the direct reaction is positive, some bilirubin has resorbed into the circulation from the bile cannaliculi.

The characteristic changes and findings in the hepatocellular type are: increased delayed-reacting bilirubin; increased urobilinogen in the urine; diminished hippuric acid synthesis; diminished serum albumin; diminished cholesterol ester fraction; positive cephalin cholesterol test; positive thymol turbidity.

In the cholangiolar type the finding are: increased prompt reacting bilirubin; bilirubinuria; increased total cholesterol; increased serum alkaline phosphatase.

While hepatocellular liver functional derangement is seen in hepatitis, as is also in cholangiolar derangement, in many instances, mixtures of the two are seen. Many investigators feel, that these variations are a matter of the stage of the disease, and it is not possible to separate these forms.

Recently, two old tests have become popular again in lending themselves readily to everyday bedside diagnosis; i. e. tests for bilirubin and urobilinogen in the urine. Neefe[2] and his coworkers while studying infectious hepatitis, which had been induced in human volunteers, found that bilirubin often appeared in the urine at the onset of the disease, before the total serum bilirubin exceeded one milligram. Turner worked out a simple barium strip test for bilirubin in the urine, and this can be readily carried out in any physician's office. In addition, the Ehrlich test for urobilinogen is as simple as the previous one. Bilirubin, the chief pigment of bile, is derived from hemoglobin, by hydrolysis; the Kupfer cells of the liver remove bilirubin from the blood stream and excrete it in the bile. Under normal conditions, bilirubin, entering the intestine, in the bile,is broken down through the action of putrifactive organisms into urobilinogen which is oxidized to urobilin. Urobilin and urobilinogen are present in the stool of normal persons, and in traces, in both bile and urine. A portion of the urobilinogen formed in the intestine, is reabsorbed into the portal blood stream, carried to the liver, where it is reconverted to bilirubin.

In conditions of moderate hepatic damage, incomplete biliary obstruction; cholangitis; and hemolytic jaundice, the liver is unable to metabolize completely all of the bilirubin absorbed from the intestine, and some consequently passes into the general circulation, and is eliminated in the urine. Under such circumstances, urobilinuria, is an indication of defective hepatic function. Absence of urobilinogen in the urine, in patients with jaundice, is indicative of complete obstruction of the common bile duct, or of complete suppression of bile pigment excretion by the liver.

In studying cases of hepatitis, Watson,[3] popularized the correlated study or profile of liver function.

In non-jaundiced patients the following tests are carried out; serum bilirubin, prompt or delayed resecting; bilirubin in the urine, cephalin flocculation test; thymol turbidity test; bromsulphalein retention, and urobilinogen in the urine.

In the jaundiced patients, the bromsulphalein

2. Neefe, J. R., Miller, T. G., Charnock, F. W.: American Journal of the Medical Sciences, 245:628 (1944).

3. Watson, C. J., Hoffbauer, F. W., Evans G. T.: 1945 Medical Clinics of North America, page 363.

test is not carried out; the additional studies are serum albumin and globulin, hippuric acid synthesis, cholesterol and esters, and alkaline phosphatase.

The total cholesterol is elevated in many cases of obstructive jaundice, and in certain cases of parenchymatous jaundice, although it is normal or reduced in severe hepatic disease. The esters are diminished when there is hepato-cellular derangement, also the alkaline phosphatase is commonly normal or slightly increased.

In studying a cross section of cases of infectious hepatitis,[4] one observes, the early appearance of bilirubin in the urine, together with an early rise in the prompt reacting bilirubin; an early disappearance of bilirubin from the urine; when the serum bilirubin is still elevated; a slow subsidence of jaundice; more so in the cholangiolitic type; an early positive urobilinogen in the urine, and a persistence of this finding indicates that the disease is still active; the cholesterol esters drop early in disease; bromsulphalein retention occurs early, and rapidly becomes marked; studies in the Mediterranean theatre disclosed that persistence above 5 per cent, after the disappearance of jaundice pointed to the possibility of continued activity, of transition to cirrhosis of the liver; the positive cephalein cholesterol flocculation test, and thymol turbidity test indicated inflammation or irritation of liver cells, indicating hepato-cellular derangement, and in the resolving phases of this disease, these tests become negative; however, exceptions have occurred, where these tests remain positive.

TREATMENT

In most cases of acute liver cell injury, the diagnosis is made and treatment is begun, only after a large proportion of damage has occurred. Therapeutic efforts must therefore be directed toward the prevention of further damage and towards the aiding of natural reparative processes. Dramatically effective measures are not to be expected. The essentials in the treatment of infectious hepatitis, are: bed rest, diet, and avoiding additional factors that are injurious to the liver.

It had been repeatedly observed in the recent war that in the presence of active hepatitis, exercise will produce an exacerbation of the disease. Failure to take bed rest during the acute jaundice stage has caused cases of moderate severity to progress to a fatal outcome over a period of a few weeks. In the convalescent stage, after jaundice has subsided, and the physical findings are minimal (but before sufficient recovery has occurred) exercise may induce a return of jaundice with a severe prolonged clinical relapse. Finally, patients with acute hepatitis, put to bed early in their illness are less likely to develop jaundice than those who remain ambulatory.

With regard to diet, evidence is available that a diet high in protein is most desirable in acute liver injury. There is insufficient evidence regarding the harmful effects of fat to warrant more than moderate restriction. However, excess fat is poorly tolerated, and may result in severe anorexia. Carbohydrates should be high in order to spare protein, as well as to provide calories. In the service it was observed that patients who were undernourished at the time of the onset of the disease were likely to be severe cases, and that underweight patients, who failed to gain weight usually ran a protracted course. Malnutrition, which probably involved a deficiency in protein, was an important factor influencing the degree and duration of liver injury, in many cases. However, in private practice, most patients are well nourished, and diet is probably a less important factor. It is nevertheless, of great importance where malnutrition is present, or where there is prolonged anorexia and failure to eat; here, plasma and amino acids by the intravenous method must be administered.

Lipotropic substances, such as choline, methionine, inositol, and cystine, in the acute phase of liver injury have not produced definite clear cut results; but in certain chronic forms of liver disease, there is a definite place for these substances.

Toxic and traumatic factors include: surgical operations, secondary infections, and ex-

4. Kunkel, H. G., Labby, D. H., Hoagland, C. L.: Annals of Internal Medicine, 26:202 (1947).

posure to various toxic substances, such as, alcohol. Ether and chloroform are probably the most dangerous anesthetics. Secondary infections have a deleterious effect in infectious hepatitis. It was observed in service hospitals, that the incidence of respiratory infections was higher in hepatitis wards than in other medical wards, indicating a lowering of resistance.

Alcohol should be banned in all stages of hepatitis. It has produced exacerbations; saline purges and drastic cathartics appear to be harmful; enemas should be used. Those sedatives and opiates which are detoxified or excreted by the liver, have a prolonged effect in the presence of liver disease. Whether these drugs damage the liver is uncertain, but they should be used only with caution.

Dysfunction of the central nervous system has been described as one of the more serious complications. Recently cases of encephalomyeloradiculitis[5] (Guillain-Barre Syndrome) as a complication of infectious hepatitis, have been described.

450 Park Avenue

OPINION ROUND-UP ON INFANT FEEDING

In connection with an infant feeding survey, Medical Economics, Inc., has obtained the considered opinions of almost five hundred physicians on certain aspects of nutrition in infancy. About one half of the respondents were pediatricians; the rest, general practitioners. The approach to the problem was a fresh one, and the resulting answers represent a unique and up-to-date round-up of a good sample of professional opinion. Through the courtesy of Medical Economics, Inc., the more interesting answers (as given by pediatricians) are abstracted below:

Age at which pureed or strained vegetables are first prescribed by pediatricians:

2 months or younger	6%
3 months	33%
4 months	36%
5 months	15%
6 months or older	76%

Age at which scraped or strained meats are first prescribed:

3 months or younger	10%
4 months	7%
5 months	16%
6 months	22%
7 months	11%
8 months	7%
9 months or older	8%

Which chopped meats do you prescribe?

The order of popularity among pediatricians was (1) beef, (2) liver, (3) chicken, (4) lamb, (5) veal and (6) pork.

Where there is a choice, do you favor breast feeding or bottle feeding?

Of the general practitioners, 82 per cent favored breast feeding; of the pediatricians, 95 per cent.

What form of milk for bottle fed infants?

	Pediatricians	General Practitioners
Fresh milk	21%	20%
Evaporated milk	81%	69%
Modified liquid milk	7%	17%
Modified milk, powder	10%	9%

(Answers total more than 100 per cent because many doctors indicated multiple choices)

Preferred carbohydrate supplement

Corn syrup was favored over sugar, four to one, both by pediatricians and general practitioners.

At what age do you discontinue formula feedings?

6 months or younger	23%
7, 8, or 9 months	47%
10 or 11 months	12%
12 months or older	12%
No fixed rule	6%
	100%

At what age do you prescribe cereals?

2 months or younger	33%
3 months	48%
4 or 5 months	10%
6 months or older	3%

Preferred anti-rachitic supplement

Cod liver oil	16%
Vitamin D concentrate	8%
Vitamin D and A	62%
Multivitamin products	48%

5. Zimmerman, H. J., and Lawry, C. F.: Annals of Internal Medicine, 26:934 (1947).

STEROID HORMONES IN EXTRAPANCREATIC DIABETES *

W. H. Stoner, M.D., Bloomfield, N. J.

Consideration of the steroid hormone aspects of extrainsular diabetes requires review of the physiologic and clinical data concerning the effects of the individual steroid hormones on carbohydrate metabolism. Such a review reveals wide discrepancies between results obtained in the clinic and those obtained with animals. Evidence exists to show wide species differences in carbohydrate metabolism among mammals. Another reason for apparently conflicting results of experiment, is the use of hormone preparations of varying compositions and potencies in varying dosages with different methods and duration of administration. The inherent capacity for adaptation of the organism tends toward spontaneous correction of abnormal conditions resulting from long subjection to endocrine imbalance. This masks the nature of the primary disturbance. Hormones, like many other substances, often give diametrically opposed effects when used in small, infrequent or short period dosage contrasted with what happens with large, frequent or long period dosage. Small doses of estrogen stimulate, large doses suppress, anterior pituitary function; small doses of androgens stimulate, large doses suppress, spermatogenesis. Recognition of these facts clarifies much of the contradictory matter in this field of investigation. The clinician often errs in his attempt to transfer to his patients the results of animal experimentation; and the physiologist doubts the clinician's report when it conflicts with results in animals.

CHEMISTRY

All the steroid hormones used clinically (estrogens, androgens, progestin and the adrenocortical hormones) have been reported to influence carbohydrate metabolism. All these steroids are derivatives of cyclopentenophenanthrene. Although stilbestrol and other artificial estrogens are neither hormones nor steroids, they have effects on carbohydrate metabolism practically identical with those of the true hormone estrogens. Of the score of adrenocortical steroids, the most active in carbohydrate metabolism are those containing oxygen at carbon atom 11. Corticosterone (Kendall's compound B) is the most active; 17-hydroxy-11-dehydrocorticosterone (compound E) and 11-dehydrocorticosterone (compound A) are less active in their influence on carbohydrate metabolism. Eleven-desoxycorticosterone is considered by many investigators to have no effect on carbohydrate metabolism, influencing only electrolyte and water balance in the organism. However, several clinical reports reveal a reduction of insulin dosage in the diabetic following administration of desoxycorticosterone acetate—an action directly opposite to the diabetogenic effect of its C_{11} oxygen-bearing relatives. The residual amorphous fraction of cortical extract is without effect on carbohydrate metabolism.

PHYSIOLOGY

Among methods for studying carbohydrate metabolism are the operative procedures: pancreatectomy (partial and complete), hypophysectomy, adrenalectomy (unilateral and bilateral), thyroidectomy, hepatectomy and combinations of these. Non-operative, partial or complete, pancreatectomy has been effected by administration of alloxan, and related substances. Animals thus conditioned have been studied under many conditions of environment and nutrition—fasting, forced-fed, given only water, high and low fat, protein, carbohydrate, sodium, potassium, vitamins, etc. Isolated tissues have been studied chemically for carbohydrate and insulin contents and in the Warburg apparatus for respiratory exchange. Studies of isolated enzyme systems are contributing much to the knowledge of carbohydrate metabolism in the tissues. Cori's laboratory has recently added to the knowledge of effects of steroid hormones on phosphorylation in the hexokinase reaction. Isotope studies with tracer carbon in carbohydrate and other tagged atoms introduced into the hormone molecules, as in current studies in the field of cancer, may soon yield more definite

* Read by invitation to the N. J. Diabetes Association, January 20, 1948.

knowledge of the actual chemical reactions of intermediary carbohydrate metabolism. Respiratory quotient determinations and other respiration studies are of value in recognizing interconversions among carbohydrate, protein and fat. Nitrogen excretion determinations, non-protein nitrogen of the blood, and complete nitrogen balance studies are significant in identifying gluconeogenesis from protein. Dextrose tolerance tests indicate changes in total carbohydrate metabolism. Determinations of blood and urinary dextrose, CO_2 of the blood for ketosis, and dextrose/nitrogen excretion ratios are routine in all such studies.

These pharmacologic methods of research have led to a huge mass of facts concerning carbohydrate metabolism of which only a part has been generally accepted as applicable to the study of diabetes and other disturbances of human carbohydrate metabolism—Cushing's syndrome, Addison's disease, etc.

It is impossible to describe the action of any one endocrine gland segregated from other glands with whose actions it is interdependent. All glands of internal secretion are concerned with metabolism, and all work together in balance for normal metabolic function. The pancreas, pituitary, adrenal cortex and gonads are the glands particularly concerned in carbohydrate metabolism.

Hypophysectomy ameliorates pancreatic diabetes, while administration of anterior pituitary extracts containing the pancreatotropic factor reestablishes the diabetes with its hyperglycemia and glycosuria. The anterior pituitary is thus antagonistic to the pancreas in respect to regulation of glycemia. This diabetogenic action of the hypophysis is largely, but not wholly, mediated through the adrenal cortex. Adrenal cortex extract also is diabetogenic. When administered to hypophysectomized, depancreatized rats, it increases blood sugar and excretion of glucose and nitrogen. The hypophysis and adrenal cortex act synergistically in the metabolism of carbohydrate. Adrenocortical extract, corticosterone and dehydrocorticosterone raise the glycogen of the liver by stimulating protein catabolism, with increased carbohydrate level and increased nitrogen and potassium excretion. The hypophysis and the suprarenal act antagonistically to the pancreas by producing hyperglycemia. Normal functional regulation of the mechanism of carbohydrate handling is dependent upon the integrity of the entire endocrine system, and particularly and immediately of the pancreas, the suprarenal and the hypophysis.

Ablation of the pancreas or depression of insulin production by alloxan, etc., has the twofold effect of disturbing carbohydrate utilization and of stimulating the hypophysis to hyperfunction. Adrenalectomy or ligation of the lumbo-adrenal veins in the diabetic animal corrects the glycosuria and hyperglycemia without the use of insulin, and makes the animal insulin sensitive. Adrenal steroid diabetes is highly resistant to insulin. Cortical extract and corticosterone, but not desoxycorticosterone, increase resistance to insulin shock in mice. Only those cortical steroids that increase liver glycogen have this effect. Adrenalectomized animals maintained on high sodium chloride diet have failure of gluconeogenesis. Cortical extracts, and C_{11} oxygenated cortical steroids less effectively, restore gluconeogenesis, and increase liver glycogen. Compound E suppresses utilization of glucose associated with a rise in blood sugar and glycosuria. The source of this glucose is not gluconeogenesis but food. Massive doses of compound E give gluconeogenesis which may be inhibited by small amounts of insulin. Compound E is antagonistic to insulin. Desoxycorticosterone and other closely related adrenocortical steroids have no gluconeogenetic effect as indicated by change in nitrogen excretion. All processes of carbohydrate metabolism are retarded by adrenal insufficiency — blood sugar falls, symptoms of hyperglycemia appear at abnormally high blood sugar level, and carbohydrate is absorbed more slowly. Cortical steroids that affect carbohydrate metabolism may oxidize glucose in peripheral tissues or may form carbohydrate from amino acid deamination residues. Large doses of 17 - hydroxy - 11 - dehydrocorticosterone are powerfully diabetogenic in normal rats, giving hyperglycemia and glycosuria. Survival period of eviscerated rats is increased by cortical

extract through retarded loss of muscle glycogen. Adrenalectomy does not change the insulin content of pancreas if rats are on balanced diet and maintained on sodium chloride. In the adrenalectomized, phloridzin treated rat, cortical extract or 17-hydroxy-11-dehydrocorticosterone restores ability to synthesize glucose from lactic acid, pyruvic acid and alanine, diminishes glucose utilization and increases glycosuria, ketonuria, nitrogen excretion and glucose/nitrogen ratio. Cortical extract or corticosterone in adrenalectomized dog lowers the respiratory quotient and increases blood sugar and nitrogen excretion. Cortical hormones may influence carbohydrate metabolism by inhibiting utilization of glucose, by inhibiting glycogenolysis in the liver, by retarding deamination of amino acids and thus reducing the rate of gluconeogenesis, or by accelerating production of glycogen from glucose. Studies of tissue respiration of liver and kidney slices show adrenalectomy to retard deamination of amino acids and thus the rate of gluconeogenesis from protein by inhibiting the glycogenolytic enzymes.

Cori has shown by isotope studies with tracer carbon that carbon fragments pass through a common metabolic pool for intereonversions among all three foodstuffs, protein, carbohydrate and fat. He has also shown that blood sugar utilization is controlled by the action of anterior pituitary, adrenal cortex and insulin on the hexokinase enzyme reaction. It is probably to extensions of this interesting work with isotopes in isolated enzyme systems that we can look for greatest progress in the study of intermediary carbohydrate metabolism and diabetes.

Estrogens act on carbohydrate metabolism by stimulating production of adrenotropic hormone by the hypophysis, which in turn stimulates production of adrenal cortical hormone. Estrogens increase liver glycogen and excretion of nitrogen by stimulation of the adrenal cortex by way of the anterior pituitary. Stilbestrol raises blood sugar in fasted, castrate and intact rats. Liver glycogen is increased, more in males and in castrates; muscle glycogen is not increased; pituitary and adrenal volumes are increased, more in females. Fasted adrenalectomized rats have low blood sugar which is not raised by estrogen, but is corrected by cortical extract and cortical steroids. Blood sugar and liver glycogen are not increased by estrogen in adrenalectomized rats maintained on cortical hormone. High dosage of estrogen, as estradiol pellet implantations, increases the insulin content of the pancreas by suppressing the diabetogenic activity of the anterior pituitary and by stimulation of islet formation. Estrogens administered to monkeys with diabetes following subtotal and total pancreatectomy or from injection of crude pituitary extract, decrease blood sugar and correct glycosuria. Estrogens have diabetogenic effect in adrenalectomized, hypophysectomized, partially pancreatectomized rats, although this effect is less marked than in animals with intact adrenals and hypophysis. Estrogens have no effect on glycosuria of pancreatectomized dogs or of dogs made diabetic with anterior pituitary extract. Results of experiment with one species cannot always be transferred to another. Estrogens have been reported to aggravate experimental diabetes and stilbestrol to induce glycosuria in normal animals. High dosage of estrogen gives hypertrophy of the adrenal cortex and depresses pituitary function, and in the rat may cause pituitary adenoma with resultant functional hypophysectomy. These effects of estrogens on the suprarenal and pituitary profoundly affect carbohydrate metabolism and may be diametrically opposite under different conditions. In rats with 95 per cent pancreatectomy diabetes is more frequent and more early in males than females; castration partially protects males and sensitizes females to diabetes; estradiol protects both sexes against the degranulation of beta cells of the islets in rats with diabetes.

Less experimental and clinical work has been done with androgens than with estrogens in carbohydrate metabolism. Testicular extract has glycolytic action, gives hyperplasia and hypergenesis of islands of Langerhans, lowers blood sugar and corrects glycosuria in the diabetic animal. Testosterone propionate has a variable effect on blood sugar dependent on the pre-existing level of blood sugar, and the dosage determines the effect. There is generally a short phase of hyperglycemia followed by a considerable drop in blood sugar. Unlike estrogens, testosterone does not raise the insulin content of the pancreas. Administration of 2.5 milligrams of testosterone propionate per day to five guinea pigs gave hyperplasia of the islands

of Langerhans in one animal, hypoplasia in one and no effect in three of the animals. Ten milligrams per day for fourteen days in dogs gave consistent, considerable hypoplasia of islands of Langerhans. The volume of the pancreas is decreased by castration in guinea pigs and rabbits, and by as much as 50 per cent in birds.

In the diabetic ferret, testosterone is slightly diabetogenic, while progesterone and desoxycorticosterone have no consistent effects. Large doses of progesterone increase liver glycogen in normal ferrets. Progesterone has no effect on carbohydrate metabolism of adrenalectomized or hypophysectomized rats, but it prolongs survival of adrenalectomized cats.

THERAPY

The steroid hormones most used in therapy of diabetes mellitus are the estrogens (estradiol, estradiol benzoate, ethinyl estradiol, and estrone), the androgens (testosterone, testosterone propionate, and methyl testosterone) and certain adrenocortical substances. By steroid hormone administration, insulin dosage can be reduced and sometimes even abolished in selected cases of diabetes. Until recently this fact was ignored clinically on the theory that no advantage would result from substituting for insulin injections the more expensive parenteral hormone preparations. However, with the availability of steroid hormones, potent by oral administration, there came distinct advantage of convenience to the diabetic and to the physician. Estradiol was the earliest of the oral estrogens to be used for this purpose, but these early reports referred to the expense of the estrogen compared to the insulin it spared. Then came the less expensive stilbestrol which was used widely, particularly in Europe and in South America where it was recognized early that the use of estrogens and androgens to suppress the diabetogenic factor of the pituitary, just as they suppress the gonadotropic factor in the climacteric, is a natural sequence to Houssay's discovery of the role of the hypophysis in diabetes. With availability of the more powerful ethinyl estradiol, methyl testosterone and anhydrohydroxy progesterone, it may be hoped that necessity for insulin injection may be obviated in certain large groups of diabetics. There are numerous clinical reports of the insulin-sparing action of estrogens, androgens and adrenocortical fractions in diabetes mellitus, not only in menopausal and older diabetics, but also in younger individuals, and even in juvenile diabetes.

During pregnancy, with its usual increase in hormone levels, particularly of estrogens and progestin, glucose tolerance increases, permitting a reduction in insulin dosage. There is an imbalance of the sex hormones, estrogen and progestin, in most pregnant diabetics, and remarkable results in restoring normal balance have been obtained with massive dosages of estrogens and progesterone.

Carbohydrate tolerance changes in the menstrual cycle according to the estrogen content of the blood. It is lowest on onset of flow and highest at mid cycle. Beardwood reports a juvenile diabetic in coma at each menstrual period in whom 400 rat units of estrogen did not, but one thousand rat units did prevent these periodic comatose attacks. He used estrogens and androgens in standardized diabetics with average reduction of insulin dosage of 11 per cent and concludes that gonadal hormones are not substitutes for insulin, and that their greatest value is in stabilizing labile diabetics. He states that there appears to be no way of anticipating to what cases this form of therapy is applicable.

Nelson recommends estrogen therapy in diabetes attributable to pituitary disorders, as acromegaly or pituitary basophilism. Cantilo reports improvement in glucose tolerance in menopausal diabetics on free diet and without insulin by giving large doses of estrogens and progesterone, and androgens. Spiegelman obtained from estrogen therapy a 63 per cent reduction in insulin dosage in premenopausal, and 41 per cent reduction in postmenopausal diabetics. Gerber obtained a 32 per cent reduction in insulin requirement in a series of female diabetics 18 to 68 years of age and up to 16 years duration. He explains conflicting reports in the literature by variation in potencies and dosages of estrogens used and by duration of the disease. If diabetes is sufficiently progressed to result in permanent damage to the pancreatic islets, little effect upon carbohydrate tolerance can be expected from the estrogens. He recommends selection of cases for estrogen therapy from those groups of short duration among menopausal diabetics and diabetics of any age with stigmata of ovarian hypofunction or of hypophyseal hyperfunction. The earlier estrogen therapy is commenced in the course of the disease, the better are the results.

Cessation of ovarian function at the menopause is usually a gradual process giving the tissues, including the endocrine glands, time to adjust themselves to the new hormone levels.

Consequently, sugar tolerance decreases at the same rate after as before the natural menopause. To the contrary, the more abrupt spontaneously occurring or artificially produced amenorrhea may be accompanied by definitely decreased sugar tolerance, obesity and frank diabetes. The early menopausal period is the time of maximum susceptibility to diabetes. These facts indicate that reciprocity exists between anterior pituitary and ovary, and that upon loss of ovarian strength, the hypophysis exerts increased diabetogenic influence on metabolism. It would seem logical therefore to administer estrogens in postmenopausal and other types of diabetes in which ovarian function is diminished or hypophyseal function increased, especially since estrogens have the additional desirable property of stimulating the pancreas to increase the size and number of islands of Langerhans with augmented insulin production.

The important part played by the adrenal cortex in carbohydrate metabolism is manifest by the profound metabolic changes in Addison's disease and in tumors of this gland. Addison's disease is characterized by insulin hypersensitivity, low blood sugar, flat glucose tolerance curve and glucosuria; while hyperplasia, adenoma and carcinoma of the adrenal cortex give decreased sugar tolerance and glycosuria. Several cases of concurrent Addison's disease and diabetes have been reported. With the development of the hypofunction of the adrenal cortex, the diabetic requires less insulin. The adrenal cortex, therefore, closely rivals the anterior pituitary in its diabetogenic function. In view of these facts, it is difficult to explain the several reports of reduction of insulin dosage by administration of desoxycorticosterone. However, this need not deter the clinician from using it, for frequently salutary effects of therapy may be due simply to the general improvement in constitutional state as, for example, in the use of androgens in certain conditions not due to testicular deficiency. Desoxycorticosterone, by its action on water and electrolyte metabolism, may indirectly influence carbohydrate metabolism. Rogoff reports that unilateral denervation of the adrenal in a human diabetic gives an initial reduction in insulin requirement, but that the requirement quickly rises above the preoperative level. Bilateral denervation gives all the symptoms of Addison's disease superimposed upon diabetes. Thorne reports the spontaneous onset of Addison's disease in a diabetic in whom 17-hydroxy-11-dehydrocorticosterone gave elevation of blood sugar, lowering of respiratory quotient and increased glucose tolerance. Kohler explains the increased sugar tolerance following administration of desoxycorticosterone to its effect of increasing the process of phosphorylation. This result is in harmony with the much discussed results of Winnett who obtained definite, but temporary, lowering of insulin requirement in a series of diabetics with desoxycorticosterone.

Cornil obtained a lowering of blood sugar in male diabetics by injection of testicular extract attributing his result to a diffuse hypergenesis of the islands of Langerhans. Feil reports carbohydrate tolerance of the diabetic to be improved by testosterone propionate.

SUMMARY

Utilization of foodstuffs, including carbohydrates, is an inherent property of the cells. Hormones only accelerate or retard utilization. The mechanism is similar to that by which vitamins participate in enzyme systems concerned with intermediary metabolic chemical reactions. From the little now known of these enzyme systems and reactions required for changing even the simple compound, glucose, into water and carbon dioxide, it is evident that they are extremely complex, and that there is great versatility and intersubstitution among the hormones toward homeostasis of the metabolic functions.

Although diabetes mellitus may exist without actual disease of the pancreas, the fact remains that only insulin can specifically control the disease. However, estrogenic, androgenic, and possibly cortical steroids, with due consideration to their contraindications, are useful adjuncts to the therapy of selected patients, particularly the juvenile and the climacteric diabetic found to be difficult to control with insulin alone.

2 Broad Street

LOCAL ANESTHESIA IN OBSTETRICS

Joseph R. Fiorello, M.D., Trenton, N. J.

Many different methods and agents in obstetrical anesthesia have been investigated and tried clinically. Some have been discarded as being too dangerous for the mother and/or the child; others have been discarded because of difficulty in their application, for example, rectal ether or paraldehyde or caudal anesthesia. Others, although entailing some dangers, are still in vogue.

Any anesthetic agent or method which goes contrary to the obstetrical tenet of a "healthy baby and a well mother" is not worthy of consideration.

The method which is being presented here is not new excepting that it combines two other methods; nerve block and infiltration.

A knowledge of the anatomy of the perineal area is indispensable for doing a regional nerve block. Two main nerves supply the perineal and perianal region: the pudendal and the posterior femoral cutaneous or "small sciatica". They are derived from the five sacral nerves and leave the pelvis through the greater sciatic notch. They then re-enter the pelvis, through the small sciatic foramen where they pass close to the tuberosity of the ischium and where they are easily accessible to the nerve block. The small sciatic gives off only one branch to the vulva,—the long pudendal. The pudendal nerve divides into three important branches from the standpoint of local anesthesia. These are the dorsal nerve of the clitoris, the perineal and the inferior hemorrhoidal. In addition to the two main nerves and their branches, the ilio-inguinal supplies the mons veneris and the labia majora.

The method presented below has been tried because of several factors, not least of which is that the obstetrical department in our hospital has no anesthetist, so that it was considered desirable to retain the anesthesia in the hands of the obstetrician.

TECHNIC

The anesthetic agent used was metycaine in a 1.5 per cent solution with no epinephrin added. The anesthesia is administered when the patient is ready for delivery.

Using aseptic technic, a wheal is made in the skin midway between the tuberosity of the ischium and the anus. This blocks off branches of the inferior hemorrhoidal. The superficial area is infiltrated in a fanwise direction, then a long spinal type needle is substituted and the pudendal nerve is blocked off by first inserting the needle until it strikes the ischial tuberosity, withdrawing it slightly then placing it one centimeter medial and two centimeters dorsal to the tuberosity. Ten cubic centimeters of the anesthetic agent are deposited there, which effectively blocks off the pudendal nerve. Then, without its removal, the direction of the needle is changed and it is inserted parallel to the ramus of the pubis to the symphysis. Five cubic centimeters are deposited there and five more cubic centimeters are deposited as the needle is slowly withdrawn, blocking off the ilio-inguinal nerve, the dorsal nerve of the clitoris and the posterior labial. The process is repeated on the other side. The needle is withdrawn and reinserted at the muco-cutaneous junction of the posterior vaginal wall. This area, plus the posterior vaginal wall (the length of the needle) is infiltrated. The levator ani muscles are infiltrated separately and anesthesia is complete.

RESULTS

This series consists of 76 primipara and 24 multipara. The preponderance of primipara over multipara (ratio of 3:1) is attributable to two factors. The anesthetic method was used in primipara with greater frequency because it required some experience to time the procedure properly in multipara, hence the use of the method was instituted much later in multipara. Also, there was a preponderance of primipara in the author's practice.

The efficacy of the method was obviously open only to subjective evaluation, so that results are based on the patients' observed reactions and upon her own opinion. When the patient complained none at all or only very little, the result was noted as "good". When she complained even moderately, the result was noted as "fair". And, when she complained more than moderately, the result was noted as "poor". Each patient was asked her opinion of the anesthetic method, the answer

noted and also used in the final classification of the results.

Seventy-three patients had low forceps extraction with episiotomy, four had mid forceps extraction with episiotomy. The remaining delivered spontaneously. There were three sets of twins and four prematures.

Six patients had poor results, nine had only fair results and 85 patients had good results.

Two patients were apparently locally sensitive to the anesthetic agent, because of the appearance of edema, (in one case of massive proportions) of the vulva and entire perineal area.

Two of the patients whose results were poor apparently were refractory to the anesthetic agent, so that in these cases, no anesthesia was produced.

Post-partum bleeding was, in almost every instance, much less than it had been with other methods of anesthesia, excepting caudal, although no attempt was made to measure the blood loss. Repaired episiotomies healed well in every instance. There was no instance of perineal infection.

SUMMARY

1. In a series of 100 deliveries, local anesthesia, incorporating the principles of nerve block and local infiltration, was used. This represented the experience of one obstetrician in a general hospital without the assistance of an anesthetist. The method is described and an evaluation of its worth is given.

2. The method is valuable because:

(a) It was highly effective in 85 per cent of the cases.

(b) It was easily applied.

(c) It was entirely harmless to the baby.

(d) It was safe for the mother both locally and systemically.

689 Princeton Avenue

CONFERENCE ON MALIGNANCY

Announcement is made of an all-day conference on "Clinical Frontier Problems in Malignancy". This is under the joint sponsorship of the Somerset County Medical Society and the Somerset County chapter of the American Cancer Society (New Jersey Division).

Day—Friday, October 8, 1948.

Place—Far Hills Inn on route 31 (Between Somerville and Pluckemin).

Time—Sessions at 9:30 a.m., 2:00 p.m. and 7:00 p.m.

Moderator—Earl T. Engle, M.D., professor of Anatomy, College of Physicians and Surgeons.

Morning Session—9:30 a.m.

"Leukemia", Joseph F. Ross, M.D., Boston, Mass.

"The Pathologist's Responsibility", L. V. Ackerman, M.D., St. Louis, Missouri.

"Cancer of the Gastro-Intestinal Tract", George T. Pack, M.D., New York City.

Luncheon—12:30 p.m.

Afternoon Session—2:00 p.m.

"Role of the Family Physician", Lewis C. Scheffey, M.D., Philadelphia.

"Urologic Malignancies", R. S. Hotchkiss, M.D., New York City.

"Breast Malignancies", Frank E. Adair, M.D., New York City.

Cocktails—6:00 p.m.

Evening Session—7:00 p.m.

Banquet.

"Future of Cancer Research", Joseph C. Aub, M.D., Boston, Mass.

Rx FOR HUMAN WELFARE

Human beings require balanced diets for health and well-being. A community, likewise, cannot get along with nothing but recreational facilities . . . . or health services only . . . . or care for children alone. Like the individual man, woman or child, the community—which includes many men, women and children—needs a balanced ration of health and welfare. The Community Chest, combining many Red Feather services for health, recreation, child care and family aid, presents this balanced ration. Make your Community Chest pledge now . . . . and *give enough for all the Red Feather services.*

THE MEDICAL MANAGEMENT OF ESSENTIAL HYPERTENSION *

L. M. WALKER, M D., Ventnor City, N. J.

Primary, or essential, hypertension is not a disease in itself. It is a sign of a widespread disturbance of the vascular tree, characterized by arteriolar constriction, increased resistance to the flow of blood through the arterioles, and elevation of both systolic and diastolic blood pressure. In the early stages the arteriolar constriction is reversible, and the blood pressure is not continuously elevated. As the disease progresses, organic changes occur in the arterioles, so that the flow of blood is continuously impeded. When this takes place the blood pressure can no longer return to the commonly accepted normal; the hypertension has become "fixed". Theories of etiology have fluctuated with the medical "fashion". Today naturally, the thinking is responsive to the current flood of psychosomatic literature. Previously, the reasoning was that cellular change produced structural damage and resulted in physiologic dysfunction. This was amended to: physiologic dysfunction produces cellular changes and results in structural damage. The latest and rather generally accepted revision is that emotional disturbance results in physiologic dysfunction, followed by cellular change and structural damage.

The fundamental cause of essential hypertension is not known. The disease may well be the "wound stripe" of our alleged civilization. A hereditary factor is certainly present, and this factor can become a dominant family characteristic. Hypertension is much more common in individuals whose parents both suffer from the disorder, than in those with only one parent affected. The second generation is more likely to be afflicted than the first, and the third generation more than the second. Ayman's analysis shows that only three per cent of the offspring of two parents with normal blood pressure will develop elevation of blood pressure. Our responsibility as medical advisors is therefore obvious and inescapable.

Is hypertension precipitated by overactivity of the sympathetic nervous system, causing widespread arteriolar constriction? Or by chemical substances circulating in the blood? It is probable that, in some cases at least, both factors come into play. An overactive sympathetic nervous system may cause constriction of the afferent arterioles to Bowman's capsule in the kidney. The resultant ischaemia may produce a vasoconstrictor substance, which, circulating in the peripheral blood stream, causes widespread arteriolar constriction and hypertension. Goldblatt's experiments indicate that this mechanism does operate in some cases. I have previously reported the surgical removal of a unilateral Goldblatt kidney in a patient, who has since shown definite improvement.

DIAGNOSIS

An appraisal of the anatomic and physiologic changes which have occurred in the heart, arterioles and kidneys is of prime importance before instituting therapy. All of us can, if we are clinically curious, reasonably industrious, and intellectually honest, appraise these patients with an acceptable degree of accuracy. A careful history and meticulous physical examination are the starting points. A casual pass at the wrist, with a resultant note "peripheral arteries, normal", is dishonest. Careful palpation of the available arteries, emptied of blood when possible, inspection of the neck, the temporal area, the precordium, the suprasternal notch, and the antecubital and popliteal space for pulsations, examination of the elevated and depressed extremities, the cold pressor tests and serial blood pressure determinations under varying conditions, should be routine. This minimal physical inventory is within the clinical resources of any medical office. Often, nothing more is necessary. Further refinement of the diagnosis is appropriate if the occasion demands. Dr. David Riesman used to say that he would forgive us for not knowing, but he wouldn't forgive us for not looking—so a fundoscopy should be part of a general physical examination by all of us. This does not mean that we must all be expert re-

* Read at the Second Anniversary Meeting of The Ventnor Clinic Staff, Haddon Hall, Atlantic City, March 3, 1948.

tinoscopists, but it does mean that we should be able to recognize normal from abnormal, and request ophthalmologic help in the latter.

The kidney is primarily concerned with the excretion of water, salt and nitrogenous end products. Dysfunction of the kidney means retention of products they should get rid of, or excretion of materials that they should retain. One of the simplest methods of detecting dysfunction is the examination of the specific gravity of the urine. The performance of a urine concentration test is easy for patient and doctor alike, and may be most informative. Too often, the report of a single normal urinalysis acts as a lullaby for unmasterly inactivity. Many specimens should be examined, and a microscopic examination of the sediment is valuable only when reported by competent observers. Resist the temptation to deputize a secretary to examine urines after a wispy training period. An *accurate* analysis of the urinary sediment and chemistry is obligatory.

Proceeding up the scale of auxiliary studies a little further (but still within the possibilities of the internist's office) are the electro-cardiographic examination, the determination of vital capacity, effort tolerance studies, and fluoroscopic examination of the heart. Estimation of the plasma proteins by the copper sulphate method, the blood urea nitrogen, the hemogram, and the sedimentation rate are important. Consultation may be required for roentgenograms of the chest to demonstrate heart size, calcific plaques in the aorta, and pulmonary congestion. X-ray sometimes demonstrates pulmonary congestion before it can be recognized by physical examination. A scout film of the abdomen may reveal an abnormality in the urinary tract or sclerosis of visceral vessels, and a film of the legs may demonstrate sclerosis of the femoral, popliteal or tibial arteries. Intravenous pyelography, in addition to revealing uropathies, is one of the better excretory tests. A benevolent providence has endowed most of our organs with so much reserve that much damage may exist before reflecting itself in any of the examinations mentioned.

After this inventory has been struck, it will generally be possible to catalog the hypertensive patient as:

Group I, with mild narrowing and sclerosis of the retinal arteries, but no cardiac enlargement and a variable blood pressure.

Group II, with a blood pressure that hits the higher brackets and is more sustained, in a patient with more marked changes in the retinal vessels, but whose cardiac and renal function is satisfactory.

Group III, with more sustained and higher blood pressure, with angiospastic retinitis, sclerotic changes in the arteries, and evidence of diminished cardiac and renal reserve.

Group IV, evidence of cardiac and/or renal failure, with edema of the disc, diffuse retinitis with hemorrhages and exudates.

Only after a patient has been so classified, is one justified in blue-printing the therapeutic approach.

TREATMENT

With the ever-present danger of oversimplification, treatment can be stated as rest, physical and physiologic. Psychotherapy is probably our number one therapy. That means emotional rest—Osler's "aequanimitas". Dr. Alvarez, at the A.M.A. in 1947, pointed out that it was up to all of us to become good psychiatrists as well as internists if we really want to get people well. The day of the straight "organicist" or the straight "psychosomaticist" has gone. However, I must stress the importance of "iatrogenic disease". This means "doctor-caused disease", and nowhere in the whole sphere of medicine is an inordinate frown, an unconscious shrug of the shoulders, or a misdirected comment capable of more trauma. In no disease does our "bedside manner" carry such a high psychogenic charge as in "blood pressure". These patients, more often than not, need a chance for ventilation and orientation. The formal couch technic of the psychoanalyst is usually unnecessary. The sympathetic ear of the family physician, and the intelligent prescription by the same individual, are often most helpful. Psychosomatic medicine or psychotherapy is no innovation. The family doctor of years gone by didn't have to inquire into his patient's trials, frustrations, failures or conflicts. He knew them.

In this accelerated urban era some of the art of medicine has perhaps been sacrificed to instrumental technics, and the doctor must take time to explore these conflicts. This can not be done in a single hurried visit. Repeated

interviews are necessary, but many patients will not keep an appointment simply to come to the doctor to "complain". Any technic that makes them keep a regular appointment for these semi-analytic sessions is justifiable, even if it means giving them hypodermics of thiamin chloride or some placebo. Remember too, to keep these people occupied with productive activities. Encourage them to participate in a handcraft where they can see the fruit of their efforts. Don't put them to boondoggling, as many of us like to say, just to "take their minds off themselves". They must be insulated against physical and intellectual boredom. Put them in as protected an environment as you can, but don't advise a laborer to take a six months' vacation in Southern California and to work half a day the rest of the year. Compromises are often necessary. Many would prefer to live six months on moderation, rather than six years on deprivation—particularly when we cannot guarantee them the six years.

The hypertensive female, whether her age is twenty-five or sixty-five, is, too often, hastily labeled "menopausal state". Then ensues a two to ten year moratorium for patient and physician alike, to avoid accepting anxiety as the etiologic culprit. But the inevitable day of reckoning has to come, and years of trauma can probably be charged to our cowardice. Many of us are afraid to face the real issue and perhaps lose a patient by having the effrontery to blame it on anxiety.

Physiologic rest means moderation in all things. It means no tobacco. It means loss of weight for the obese and frequent small meals for those who practice dietary indiscretions. Running after a trolley car is not the only effort to ban. It is to be remembered that the digestion of a large meal is often just as taxing on the circulatory apparatus.

Drug therapy comes under physiologic rest. If we believe the detail men or the pretty dash-dot graph lines of the medical journal advertising, the control of blood pressure would resolve itself into the taking of one small tablet four times a day. It is doubtful if, in most cases, vasodilators do any good *except* for the stockholders of the manufacturing company. But it is psychologically difficult to have the patient leave the office with a set of medical instructions that does not contain some medication. Although I cannot approve of the habitual use of phenobarbital, I have often found it a valuable drug in detaching the hypertensive host from reality or diminishing the acuity of his appreciation of distress.

Not everybody is cynical about drug therapy in hypertension. A recent meeting of internists in Philadelphia was almost a hair-pulling match because of a discussion on thiocyanates. Even under optimum laboratory control, this is a dangerous drug, and I do not use it. New drugs are being investigated constantly, including kidney extract and attempts at deamination of pressor amines with tyrosinase and quinones, none of which offer safe or spectacular results as yet.

No medical remarks would be complete without a reference to diet. Twenty-five years ago, Dr. Frederick M. Allen was sure that salt restriction was the answer to hypertension. Then this thesis fell into disuse. Now it is being revived, and Kempner has won disciples for the rice diet. In his own words; "many patients adjust to it and some few even like it". From personal experience, I can say it is easy of prescription, but difficult of execution. Some of the new resins may prove selective enough to pick out the sodium from the diet.

5407 Atlantic Avenue

OBESITY AND HEART DISEASE

Transient hypertension, transient tachycardia, or overweight increases the probability of subsequent hypertension or cardiovascular-renal diease. In an analysis of the records of 22,741 officers, Levy and associates find that probability of death from cardiovascular-renal disease is minimal when overweight alone exists; but when transient hypertension and transient tachycardia are also present, the rate for later development of cardiovascular-renal disease is four times as great as for men without such complications. If all three conditions occur, the probability of sustained hypertension is twelve times as great. — *J.A.M.A. 131:951.*

PARA-TYPHOID COMPLICATED BY TOXICO-DERMA AND JAUNDICE

MAX BRAITMAN, M.D., and JACOB A. RIESE, M.D., West New York, N. J.

Jaundice as a complication of salmonellosis is uncommon. Because salmonella infection may be the underlying cause of icterus in what would ordinarily pass as a case of "catarrhal jaundice" it is important to include the para-typhoid group of organisms in the differential diagnosis. The following case is reported because of the unusual combination of a skin lesion followed by jaundice, after the ingestion of raw clams.

This 33 year old male was first seen by the senior author December 11, 1947, complaining of an eruption on the body for three weeks. There was no previous history of any similar lesion. The eruption was intensely pruritic and had not responded to therapy. He stated that three days prior to the onset of his trouble, he had eaten a large number of raw clams and had consumed a "good quantity" of liquor. History did not include any gastro-intestinal upset, abdominal pain, diarrhea or fever.

He presented a generalized eruption, consisting of large red grouped macules and papules, involving the entire body, including the palms and soles, and most marked on the trunk and extremities. Mucous membranes were free. Uninvolved skin was of normal color and the conjunctiva were clear.

A diagnosis of toxico-derma (erythema multiforme) was made. Serology reported on December 15 was negative.

The patient received calcium gluconate intravenously and orally. X-ray therapy was given to the back and thighs. Potassium permanganate baths and a mild emulsion were prescribed for topical use. Pyribenzamine 100 milligrams four times a day (which he had been taking) was continued.

There was slight improvement over the next few days. (Twenty cubic centimeters of blood as autohemo therapy was given.) Hydryllin was substituted for pyribenzamine which had had little effect, but could not be tolerated.

A urine report on December 17 was positive for bile pigments and the methylene blue test for bile was positive. Examination the next day revealed, for the first time, a definite generalized jaundice. The patient reported that jaundice and a dark urine had been noticed for several days; that the stool was yellow. There was no fever. The itching became generalized and intense.

At this point he was referred to the junior author.

The liver was found to be enlarged two finger breadths below the costal margin, had a smooth edge, and was slightly tender to palpation. Blood count was normal. Blood culture and a Widal examination were negative. The Van Den Bergh was biphasic and showed a serum bilirubin of 43 milligrams. Urobilinogen was faintly present in the undiluted urine specimen. Stool culture was reported twice as positive for salmonella. Stools were clay colored and showed a faint trace of occult blood. The patient was placed on sulfadiazine, with high protein, high carbohydrate, low fat diet, and large quantities of vitamins, yeast extract, and intra-muscular injection of liver. The jaundice disappeared in the eighth week and subsequent stools were negative for salmonella organisms. The patient continued to complain of weakness and occasional diarrhea for another month. He is now on the way toward complete recovery.

Para-typhoid infection is frequently associated with the eating of shell-fish. Tice [1] lists jaundice as a complication of such infection. Smith [2] found one case of jaundice in 40 cases of para-typhoid observed and treated. Salmonella infection is primarily a bacteremia and among other organs it may attack the liver causing a hepatitis with jaundice. The typhoid group of organisms do not involve the stomach or duodenum as a rule. The hepatitis is probably caused by an ascending biliary tract infection which starts in the gall-bladder.

Toxico-derma improved as the jaundice improved and the skin had cleared after four weeks, leaving a residue of skin blemishes

1. Jennings, C. G., in Tice, Frederick: Practice of Medicine, Hagerstown, Md. W. F. Prior Company, 1930, 4:640.

2. Smith, A. Lucian: Experience in Military and Civilian Practice, Gastro-Enterology, 7:551 (Nov.) 1947.

where the lesions had been. Toxico-derma or erythema multiforme is often seen associated with infection of any type. The type of eruption varies, but is usually urticarial, of a long, rather than short duration, generalized and extremely pruritic. The duration may be of several weeks depending on the underlying cause. Treatment is directed to removal of etiologic factors plus soothing baths and lotions, anti-histaminics, free fluids, and high carbohydrate diet.

CONCLUSION

1. A case is presented of salmonella infection complicated by toxico-derma and jaundice.

2. It is well to keep the para-typhoid group of infections in mind whenever a case of infectious hepatitis with jaundice presents itself.

412 - 60th Street, West New York, New Jersey
6012 Palisade Avenue, West New York, New Jersey

BOOK REVIEWS

Psychopathology and Education of the Brain-Injured Child. By Alfred A. Strauss and Laura E. Lehtinen. 206 Pp. New York, Grune & Stratton, 1947. $5.00.

Throughout the book, the problems of a brain injured child are clearly depicted, and the need for special educational technics are stressed. The diagnosis and differential diagnosis from neurotic and psychopathic personality disorders, from childhood schizophrenia, from familial or endogenous mental deficiency, and from malformations of the brain are discussed.

A brain-injured child is defined as one who before, during, or shortly after birth received an injury to, or suffered an infection of the brain. If there is organic impairment, there may be neurologic signs and the child will show disturbances in perception, thinking, and emotional behavior. The authors say that the *amount* of brain substance destroyed, rather than the localization of the destruction, is responsible for the particular psychologic disorder.

Several tests are described to show that in brain-injured children there is an "imbalance in the perception of foreground and background". Brain-injured children have a "forced-responsiveness" to the background and are easily disturbed by a background of varying visual, auditory, and kinesthetic cutaneous perceptions. Associated with this "forced-responsiveness" are the characteristics of "perseveration" and the "catastrophic reaction".

The catastrophic reaction is the disordered behavior manifested by the brain-injured child when he is confronted with a task beyond his ability. From a feeling of elation, the brain-injured child (when confronted with a difficult task) may suddenly experience a reaction of rage, anxiety or depression. In young children it may appear in the form of intense crying.

To overcome these disturbances, the authors reduced external stimuli to a minimum. The class room is away from the outside disturbances. The class group is very small. Seats are widely separated. Pictures are absent for the first half year of the child's attendance in a special class. Teachers wear plain dresses without ornamentation. Writing materials and books are divested of everything but the merest essentials.

JOSEPH E. MAST, M.D.

Biology of Disease. By Eli Moschcowitz, M.D., Pp. 221. (Mt. Sinai Hospital Monograph No. 1) New York, Grune & Stratton, 1948. $4.50.

Purpose of these essays is to stimulate a point of view, rather than to furnish information as in the usual medical article, and to emphasize the dynamic as opposed to the static approach in the study of disease. This is based on the fact that many diseases are not sharply defined genera, but transitions of morbid states from one to another. The futility of classifying diseases according to grouping of signs and symptoms is apparent.

The value of regarding chronic disease as presenting an evolution from the primitive or embryonic to the full-fledged form is emphasized. A small field of internal medicine is covered in this volume, the topics ranging from hypertension of the pulmonary circuit, to periarteritis nodosa, leukemia, myeloma, obesity, cardiospasm, psychosomatic medicine, the "hyperkinetic diseases" and others.

Libman-Sacks disease, for example, is regarded as compounded of a variety of clinical phenomena ranging from a larval or primitive type to a more or less complete form, between which various symptom complexes arise that have been previously viewed as separate disease entities. Likewise, in discussing the relation of neurocirculatory asthenia to Graves' disease, the view is taken that the former presents so many "features in common with the larval or constitutional phase of Graves' Syndrome, that the two can be regarded as identical".

Studies of this type, emphasizing a biologic rather than a static approach will synthesize rather than disintegrate disease complexes, and provide stimulation to the thoughtful physician.

I. J. BERNSTEIN, M.D.

Treatment in General Practice. By Harry Beckman, M.D., 6th ed., Pp. 1129. Philadelphia. W. B. Saunders Company, 1948. $11.50.

The latest edition of this standard medical work follows its predecessor by only three years. Within this brief period, contributions to our medical knowledge have made necessary many revisions and additions to the older edition.

The material is well organized. For each disease entity there is a brief general consideration which includes, where indicated, features of distribution, etiology, epidemiology and clinical manifestations. There follows an orderly and extensive review of the appropriate therapeutic measures.

Unlike most medical texts of its kind, which are multi-authored, this work represents the evaluation by one man of a vast field of medical experience. Many subjects must certainly have been outside his personal clinical range. This obvious disadvantage is more than offset by a consistently readable, and often humorous style, a single, mature objective viewpoint, and a fine attention to the often neglected problem of supportive therapy.

A fairly extensive bibliography and a good index conclude the volume. It is recommended for all general practitioners and medical libraries.

JAMES W. BARRETT, M.D.

Paravertebral Block in Diagnosis, Prognosis, and Therapy. By Felix Mandl, M.D., Pp. 330. New York, Grune and Stratton, 1947. $6.50.

Paravertebral block has taken its place as a boon to mankind in making the extended life expectancy more livable. It is successful in treating many difficult conditions. Felix Mandl in this book gives the result of his twenty-five years of experience and investigation in the use of paravertebral block. He analyzes its indications and its value, and enumerates cases where it is of no value. The text is clearly and simply written. The case reports presented are illustrative of the points made and are not used just to provide bulk. This book should prove useful to all who deal with disorders of the sympathetic and parasympathetic nervous system and with patients in pain. The foreword by Max Thorek is excellent.

WILLIAM EHRLICH, M.D.

The Battle of the Conscience. By Edmund Bergler, M.D. Washington Institute of Medicine, Washington, D. C., 1948. Pp. 296. $3.75.

What the old fashioned observer used to call the "conscience" has been designated the "ego-ideal" or "superego" in psychiatric jargon. To most students of abnormal psychology, the conscience has been seen as a negative force, a restricting and repressing censor, capable of suffering its own diseases as noted in the hypertrophy of the conscience in the depressed patient and its atrophy in the psychopath. Bergler gives this concept a novel twist, by analyzing the conscience as a dynamic, positive force. He puts especial emphasis on the unconscious aspects of the superego, and works out the ways in which we appease it. The entire mechanism rolls on steadily behind the iron curtain that separates consciousness from the unconscious; and it takes a lot of digging to drag it out into the light of day. Bergler does it, describing the devious bargains with which we appease the inner conscience. The non-psychiatrically trained reader will find it heavy sledding, ploughing through almost 300 pages of tightly written prose, punctuated by somewhat forced efforts to use dramatic phrases-touches which somehow fail to lighten the pedestrian pace of the text. For the serious reader, willing to take his time, the volume will prove to be interesting, novel and thought-provoking.

HENRY A. DAVIDSON, M.D.

War, Politics, and Insanity. By C. S. Bluemel, M.D. Pp. 121. World Press, Inc., Denver, Colorado, 1948. $2.

Long distance diagnosis is probably as risky in psychiatry as in any other branch of medicine. For that reason, the reader will find Bluemel's psychiatric postmortems interesting rather than instructive. He believes that Napoleon was a manic depressive, Goering a psychopath, Stalin an obsessive compulsive, Hitler a schizoid and Mussolini a hypomanic. These are cited to support the author's thesis that the trouble with the world is that leadership too often falls into the hands of emotionally unstable, if not downright psychotic persons. He argues that most leaders are extroverts (though the century's chief mischief maker, was certainly a schizoid), and that when this is combined with obsessive, compulsive, and aggressive traits, the resultant personality is a dangerous and explosive one. No attention is paid to the old controversy as to whether events make men or men make events. The author is clearly in the latter camp, and makes no allowance for the possibility that events may shape, indeed may produce, the leaders. The book provides a pleasant evening's reading, and will furnish any doctor with food for thought and a springboard for an hour of lively staff-room or parlor conversation. The author's solution to the problem is absurdly juvenile; he wants the franchise limited to college graduates and administration entrusted to a counsel chosen *by lot* from among senior citizens who have passed psychiatric examinations. Except for this crotchet (which is embodied in the final chapter, and easily skipped) the book is a mature and stimulating one. My favorite phrase is the author's account of how a filibuster may interfere with the democratic process: "Since the filibuster is an endurance contest, the passage or defeat of important legislation may be determined by the capacity of the speaker's bladder".

JOSEPH SANTANGELO, M.D.

REPORT OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION

New Jersey's five elected delegates to the American Medical Association were present at all sessions of the House of Delegates during the Annual Meeting of the American Medical Association in Chicago, June 20 to 24, 1948. In addition to the delegates (Drs. Thomas K. Lewis. Hilton S. Read, J. Wallace Hurff, Joseph F. Londrigan, and William F. Costello) other members of the official family of The Medical Society of New Jersey were present at one or more meetings of the House of Delegates. These were Dr. J. Howard Hornberger, President; Dr. James F. Norton, President-Elect; Dr. Norman M. Scott, Medical Director of Distribution of Medical Care; Dr. Frederic J. Quigley, Executive Secretary, Legislative Committee; Dr. William E. Bray, Chairman, Sub-Committee on Public Relations; Dr. Earl LeRoy Wood, Secretary, and Mr. James E. Bryan, Executive Officer.

The delegation held a preliminary meeting on June 20, and approved the five resolutions forwarded to them for submission to the House of Delegates. Plans were made for representation at meetings of reference committees considering matters in which The Medical Society of New Jersey was especially interested.

In its first order of business, the House of Delegates conferred the distinguished service award of the A.M.A. upon Dr. Isaac Abt of Chicago.

The Speaker appointed Dr. Londrigan a member of the Reference Committee on Medical Education, and Dr. Costello a member of the Reference Committee on Amendments to the Constitution and By-Laws.

The House considered in executive session a resolution proposed by the New York State Delegates designed to compel county medical societies in the South to admit Negro physicians on an equal basis with white physicians. This was disposed of by reiterating the principle "that the component medical society is the sole judge as to whom it elects to membership, provided the applicant shall meet the medical requirements for membership."

The House adopted a report of the Council on National Emergency Medical Service, including a recommendation that each state association and its component county societies organize committees on national emergency medical service; that the names of members of such committees be filed with the A.M.A. and that each state society cooperate with the Council on National Emergency Medical Service in developing local programs "related to national defense".

The House took note of the fact that thirty-two percent of the physicians throughout the United States are not members of the American Medical Association and recommended that the Board of Trustees of A.M.A. "initiate a strong and persevering drive for new members extending through the constituent associations to the component societies where vigorous committees should seek to enroll every eligible doctor". *(Note:* The House of Delegates of The Medical Society of New Jersey on April 29, 1948, recommended to component county medical societies that they conduct a "dignified membership drive" during the coming year.)

Four resolutions introduced by the New Jersey delegates were reported on by the Reference Committee on Legislation and Public Relations under the chairmanship of Dr. Thomas A. McGoldrick of New York. One of these urged the American Medical Association to enter formal protest against the policy of the United States Children's Bureau which stipulates that state agencies operating tax-supported programs for crippled children must require that surgical services and prescriptions for prosthetic appliances be certified by diplomates of the American Board of Orthopedic Surgery. This resolution was approved by the House and provides that the A.M.A. will enter a formal protest against this policy with the Federal Security Administrator, "recommending to him that the Administration's policy be liberalized to permit participation on a state level by all physicians qualified".

Another New Jersey resolution adopted by the House provided that "The American Medical Association hereby strongly reiterates its opposition to the extension of federal grants-in-aid to any state for any health or medical service except where such state has clearly demonstrated an absolute need for such Federal assistance"; and further provided that the Board of Trustees of the A.M.A. "be directed to withhold the approval of the A.M.A. from any legislation pending or hereafter proposed unless this principle is embodied in such legislation".

A third New Jersey resolution, characterizing biologic and bacteriologic methods of warfare as inhumane and recommending that such technics of warfare be specifically outlawed by international covenant, was considered but no action was taken.

The House referred to the Bureau of Medical Economic Research "for study" a resolution presented by the New Jersey delegates requesting that the Board of Trustees of A.M.A. negotiate with representatives of the life insurance industry in an effort to obtain a nation-wide upward adjustment in the level of fees paid by insurance companies to physicians for regular medical examinations, as well as for other medical services rendered on request of life insurance companies for their policy holders.

A fifth resolution presented by the New Jersey delegates, which would have changed the name of the Bureau of Health Education to "The Bureau of Child Health and Health Education", was not adopted on the ground that the phrase "health education" is an all-inclusive term.

Other important actions of the House of Delegates include:

A resolution reiterating the principle of free choice of physician for medical care for veterans and urging state medical societies to conform to this principle when making agreements with the Veterans Administration.

A resolution calling for an investigation of alleged leftist tendencies on the part of the "Association of Interns and Medical Students".

Impetus was given to an effort to obtain large funds for medical education by public donation in order to obviate any need for governmental subsidy and control of medical schools.

The House of Delegates rejected all proposals to require the Council on Medical Education and Hospitals to condition its approval of the educational programs of medical schools and hospitals on questions relating to the financial agreements made by such institutions with staff members. It was generally agreed that the granting of approval of such institutions by this council should be solely on the basis of educational standards. The House concurred in the opinion that any other course would be "unwise and possibly illegal."

Meanwhile, several resolutions dealing with medical schools and hospitals engaging in the practice of medicine were referred to a special committee on Hospitals and the Practice of Medicine under the chairmanship of Dr. Elmer Hess of Pennsylvania.

The House of Delegates supported efforts of its Board of Trustees to bring about changes in the income tax laws in order to permit physicians, as small proprietors or as partners, to deduct the costs of pension programs for themselves in computing income taxes.

The Delegates altered the by-laws to provide that the Council on Medical Education and Hospitals should include at least one private practitioner not connected with any institution, medical college or university. This action was originally proposed by the delegates from New Jersey and was strongly supported by them.

The House adopted a resolution providing "that in order to preserve the general practice of medicine, the American Medical Association institute a program to allocate the number of interns of all approved hospitals on an equal basis according to yearly admissions."

Acting upon several resolutions critical of the action of the Board of Trustees in taking out medical care and hospitalization insurance for employees of the A.M.A. through a private insurance company and abandoning a hospitalization contract with the local Blue-Cross Plan, the House of Delegates recommended that at the expiration of the term of the present insurance, the A.M.A. make every effort to procure this coverage for its employees through the Blue-Cross—Blue-Shield local organization.

The Delegates approved a classification of nurses into (a) professional nurses, subdivided as (1) nurse educators and (2) clinical nurses; and (b) trained practical nurses. It recommended for trained practical nurses, one year of training, made up of three months theoretical and nine months practical training. It recommended that social security and retirement plans be provided for all nurses; that hospitals adopt a definite personnel policy for institutional nurses with a view to making salaries, hours, sick leave and vacations comparable to those in other fields for women with equivalent education and training; and that the cost of special nursing care for the patient be covered by prepayment nursing plans to be tied in with prepayment hospital and medical plans if practicable. The Delegates were critical of the recent decision of the nursing group to have their professional organizations act as bargaining agents for them. "The term 'bargaining agent,'" the House of Delegates pointed out, "carries with it an implication to strike, even though it is true that they have never gone on strike. Medical men, nurses, and other hospital employees have not the right to strike anywhere or anytime. . . It is hoped that the nurses will correct this in the near future."

The House of Delegates received a number of resolutions critical of the policies of the American Red Cross in its national blood bank program. A reference committee report on this subject adopted by the House reaf-

firmed "approval in principle" by the A.M.A. of participation of the American Red Cross in the national blood bank program. However, it called attention to the existence of many local programs operating under the auspices of the medical profession and hospitals, which are rendering "invaluable service to the community". The House voted that the "approval in principle" of the A.M.A. should be construed with the following limitations: *first,* that local control should be exercised by the county medical society; *second,* that the local medical society should be the agency of first contact where a new blood bank is contemplated; *third,* that no publicity should be released except by common consent of the local medical society and local chapter of the American Red Cross; *fourth,* that differences of opinion in respect to administrative or technical details should be arbitrated at state levels by joint committees representing the medical society and the American Red Cross.

The Delegates further provided for expanding the size of the committee of the A.M.A. on cooperation with the Red Cross, urging that that committee meet more frequently and that it make a report to each meeting of the House of Delegates. Finally, the House adopted a statement that "any provision of free medical service or supply to everyone without regard to ability to pay is in opposition to the principle that it is the responsibility of an individual to assume the obligations of medical expense just as he does for other living expense," and further declaring that the A.M.A. "deplores the use of the term 'free blood' in the publicity of the American Red Cross."

The House adopted a resolution urging the President of the United States and the chairman of the National Security Resources Board to take action for immediate establishment of a civilian medical coordinating board as a functioning part of the National Security Resources Board.

The Delegates adopted a resolution requesting provision for payment for services of physicians engaged in examination of registrants for the armed forces under the peace-time draft.

The Delegates referred to the Board of Trustees a resolution (proposed by the Rhode Island Medical Society) expressing its dissatisfaction with the fact that the A.M.A. has not yet made a complete study of existing and proposed compulsory temporary disability compensation programs, which the House of Delegates in 1946 requested to be made prior to January 1947. The House of Delegates approved a report of its committee to study conditions of general practice, containing these recommendations: *first,* that qualified general practitioners have staff privileges and representation on hospital staffs; *second,* the further utilization of community hospitals for training of general practitioners; *third,* that the A.M.A. be the evaluating agency in medical education, both graduate and undergraduate; *fourth,* that there be the closest possible liaison with all other agencies and organizations; and *fifth,* that general practitioners be encouraged to participate in the scientific and organizational activities of organized medicine.

The House approved a report providing that the Bureau of Legal Medicine and Legislation of A.M.A. make a study of various state laws defining the status of corporations attempting to practice medicine; and providing that the Board of Trustees write again to all of the hospitals and medical schools, reminding them of the principles and policies of the A.M.A. concerning the practice of medicine by such institutions and asking these agencies to conform to the A. M. A.'s principles.

In executive session the House considered, among other things, the question whether it is desirable to establish a national insurance company to provide voluntary medical care insurance on a national basis for firms and groups operating nationally. At length this question was referred to the Board of Trustees with the understanding that it is to receive recommendations from the Council on Medical Service.

The election of officers resulted in the designation of Dr. Ernest Edward Irons of Chicago as president-elect who will take office at the Atlantic City session, June 6, 1949. Besides the president-elect, other offices filled by the House were:

Vice-president—Roy W. Fouts, Omaha.
Secretary—George F. Lull, Chicago.
Treasurer—Josiah J. Moore, Chicago.
Speaker—Francis F. Borzell, Philadelphia.
Vice-speaker—James R. Reuling, Bayside, N. Y.
Trustees—Gunnar Gundersen, La Crosse, Wis., (1953); Edward S. Hamilton, Kankakee, Ill., (1953); and Walter B. Martin, Norfolk, Va., (1951).
Judicial Council—John H. O'Shea, Spokane, Wash.
Council on Scientific Assembly—Alphonse McMahon, St. Louis.
Council on Medical Education and Hospitals—Harvey B. Stone, Baltimore, and William L. Pressley, Due West, S. C.
Council on Medical Service—Henry B. Mulholland, Charlottesville, Va., and Joseph D. McCarthy, Omaha.

The 1949 session will be held in Atlantic City, the 1950 session in San Francisco, and the 1951 session in Atlantic City once more.

James E. Bryan,
Executive Officer.

WANTED BY THE FBI

Hugo Bob Hubsch, with aliases Robert C. Glass, R. C. Harris, Hugo Hobsch, Louis S. Miller, is being sought by the Federal Bureau of Investigation. He is charged with violations of the national Stolen Property Act. This individual has defrauded numerous physicians and hospitals in eastern United States during the past few months through the medium of fraudulent checks.

Hubsch has a chronic kidney ailment and a large kidney stone in the right ureter. This has caused inflammation which, at varying intervals, results in severe pain. He has been advised that it would be necessary for him to undergo surgery for the removal of the stone and until that surgery is performed he will need frequent medical attention. This fugitive moves about rapidly and recently he has given numerous physicians and hospitals fraudulent checks in return for treatment, hospitalization, sedatives and narcotic prescriptions.



The following is a composite description of Hugo Bob Hubsch: Age, about 52; height, about 5′ 6″; weight, 140 to 170 lbs.; hair, dark brown, graying; eyes, brown; build, medium; race, white; occupations: laborer, pharmacist; paresis of left arm, needle scars on both arms, large scars above each hip from kidney operations, shrapnel scars and two bullet scars on abdomen, bridge in upper front teeth; characteristics: long nose, stooped posture.

Anyone having information concerning this fugitive should immediately notify the nearest office of the Federal Bureau of Investigation or a local law enforcement agency.

OBITUARIES

DR. GEORGE W. FITHIAN

The Medical Society of New Jersey lost one of its senior members on August 9, 1948, with the death on that date of Dr. George W. Fithian of Perth Amboy.

Dr. Fithian was born in Greenwich, N. J., in 1876, and was graduated from the Medical School of the University of Pennsylvania in 1899. The following year he returned to New Jersey and entered private practice in Perth Amboy. Active in civic and welfare affairs, he was appointed city physician for Perth Amboy in 1918 and served at the same time as a member of the Middlesex County Draft Board in World War I.

In 1921 he was elected president of the Middlesex County Medical Society and in 1931 he became surgeon to the Port of Perth Amboy. For three years he represented Middlesex County on the Welfare Committee of the state society. In 1941 he was elected a member of the Board of Trustees of The Medical Society of New Jersey and he served actively on that board until the day of his death.

During most of his professional life he was closely identified with Perth Amboy General Hospital. On attaining the retiring age he was made emeritus surgeon to the hospital. He continued in active private practice and for the last few years had been considered the dean of medical practitioners in Perth Amboy.

DR. MORTIMER H. WEISS

At the untimely age of 48, Dr. Mortimer H. Weiss of Newark, died suddenly on August 6. He was en route to the shore to rejoin his family, and suffered a cerebral hemorrhage while about to visit a patient in Point Pleasant. Dr. Weiss, in spite of his youth, had served in both world wars, having been a private in a medical detachment in 1918, and a flight surgeon in the European Theatre from 1942 to 1946. He was on the gynecologic staff at the Newark Beth Israel and also worked part-time in the surgical department of the Veterans Administration.

Though born in New York, Dr. Weiss spent most of his life in Newark, and had been intimately identified with many local civic, medical and organizational activities. He received his B.A. degree from Columbia University in 1921, and his M.D. from the College of Physicians and Surgeons of Columbia in 1925. He had been a member of the Essex County Medical Society since 1926, and served for several years as president of the Associate Staff of the Beth Israel Hospital. In July he was notified that he had passed the first part of his American Board examinations in gynecology and he was looking forward to finishing the examination and earning his certification next spring, when, with shocking suddenness, his death intervened.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

Recommended daily dietary allowances have just been issued by the Food and Nutrition Board, National Research Council. These give the recommended allowances of food constituents for men, women and children with various degrees of activity. Copies may be secured from the State Department of Health, Trenton 7, New Jersey.

CANCER FILMS NOW AVAILABLE

Cancer films for use by county medical societies for professional showings are available from the State Department of Health, Trenton 7, New Jersey, without charge. These are 16 millimeter silent films. Projector and operator must be supplied locally. These are not for lay group use. A number of films are available for lay group use and a catalog of these may be secured from the State Department of Health.

The cancer films now available include "Living Cells" produced by Canti at Strangeways Research Hospital. It shows the technic of tissue culture and its application in research. Another film is called "Various Aspects of Cells and Living Tissues" by Chambers and Gerard. This is from the Department of Biology, New York University.

A third film "Pre-cancer Diagnosis of the Cervix by Cytology" produced by J. E. Ayre, M.D., will be available after October 1. This 16 millimeter sound film is in color and can be used only with a sound projector.

TREATMENT OF NEUROSYPHILIS

The Division of Venereal Disease Control will no longer supply tryparsamide for the treatment of neurosyphilis. Complicating sequelae (such as amblyopia and tubular vision) have been attributed to this drug. It should never be used where facilities for appropriate eye examination are not available. Penicillin alone or combined with hyperpyrexia is the treatment of choice now.

In the third edition of *Modern Clinical Syphilology,* Stokes states that: "the medicolegal responsibility of the physician in cases of amblyopia due to tryparsamide has been affirmed by a decision of the Supreme Court of Appeals of Virginia (J.A.M.A., 1941) in which it was ruled that tryparsamide is a potent drug which should be administered only under ocular control."

HOSPITALIZATION OF SYPHILIS

Funds are available to continue hospitalization of all classifications of syphilis for the fiscal year which began in July 1948. Mentally disturbed patients should go to state hospitals. Other cases of central nervous system syphilis may be sent to any of our cooperating hospitals when beds are available. The state plan's treatment schedule is:

Early syphilis, latent syphilis, late syphilis, late congenital syphilis (4 years or older)
4.8 million units (50,000 units aqueous penicillin every 2 hours) in 8 days of hospitalization.

Early congenital syphilis (under 4 years)
Dosage 10,000 units every 2 hours for infants up to 10 lbs., with dosage increased according to body weight. A convenient way to figure single doses for infants over 10 pounds is to multiply 1000 units by the number of pounds of body weight. Allow for 10 days' hospitalization.

Neurosyphilis (asymptomatic)
6 million units aqueous penicillin (50,000 units every 2 hours) in 10 days of hospitalization.

Paresis, tabes dorsalis, primary optic atrophy
12 million units penicillin (50,000 units every 2 hours) in 20 days of hospitalization.

A MILLION NEIGHBORS

Fall brings golden leaves and apple cider and *Red Feathers.* A million Americans are devoting their time and energy this autumn to help make a success of their local Community Chest campaign. *Red Feathers* decorate the lapels of workers and givers, line the streets and windows of your town and ours, from the Atlantic to the Pacific.

Earn your *Red Feather* by pledging your share for the *Red Feather Services* in your nearest Community Chest. Give . . . Give *Enough!*

COUNTY SOCIETY REPORTS

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

The annual meeting of *Hudson County Medical Society,* terminating the official year of 1947-48, was held at the Jersey City Masonic Club on the evening of May 4, 1948. The president, DR. RAYMOND S. DRISCOLL, called the meeting to order at 9:25 p. m.

The annual reports of the Board of Trustees, the Treasurer, and of various standing committees were read and accepted.

DR. EARL J. HALLIGAN, program chairman, extended a cordial invitation to the members of the Society to attend the spring conference of the International College of Surgeons, New Jersey Section, on Wednesday afternoon, May 19, 1948, at Murdoch Hall, Jersey City Medical Center.

DR. VINCENT P. BUTLER, secretary, directed special attention to the recommendation of the Executive Committee at its April 19 meeting—that the Society institute prompt action concerning the handling of night and emergency calls by the general practitioners. He announced that a survey questionnaire with respect to this matter would be circulated immediately, and requested prompt response on the part of the membership in order that lists may be compiled of all physicians who are in a position to accept night and emergency calls in their respective sections of the county.

Upon motion regularly made, seconded and carried, the secretary cast one ballot for the election of the nominees whose names were listed in the report of the Nominating Committee made at the March meeting; for the election of members of the Nominating Committee to serve in 1949 who were nominated from the floor at the April meeting; and for the election of one additional delegate and alternate to the annual meeting of The Medical Society of New Jersey, to serve to 1951—DR. SIGMUND C. BRAUNSTEIN and DR. LOUIS A. SCHNEIDER, respectively.

Preceding the scientific session, the meeting was addressed by MAJOR H. G. TOUSIGNANT, Medical Corps, representing BRIGADIER GENERAL GUY B. DENIT, Surgeon, First Army Headquarters, Governors Island. Major Tousignant discussed briefly the career plan of the new Army Medical Department now being placed in operation by the Surgeon General, which is designed to provide superior medical service for the armed forces in peacetime as well as in war. The Regular Army, he said, is extending to those physicians who can meet high professional and physical requirements, an invitation to become Medical Corps officers.

The guest scientific speaker of the evening was DR. OTTO STEINBROCKER, Associate Clinical Professor of Medicine at N. Y. U. Medical College, Chief of Arthritis Clinic at Bellevue Hospital, and attending Rheumatologist at Beth David Hospital. The subject of Dr. Steinbrocker's presentation was *Treatment in the Common Forms of Arthritis.*

The newly elected secretary, DR. JOSEPH P. DONNELLY, announced that plans are being made for the use of Murdoch Hall Auditorium (Jersey City Medical Center) in place of the Jersey City Masonic Club, for regular monthly meetings, beginning in October of 1948.

Before adjournment, the floor was given to DR. NICHOLAS M. ALTER, who on behalf of the Society thanked Dr. Butler for his zealous and valued services to the Society during the years of his secretaryship, from which office he is now retiring, and felicitated him upon his election at this meeting to the vice-presidency. Dr. Butler received an ovation.

HUNTERDON COUNTY

H. A. Davidson, M.D., Reporter

A hospital for Hunterdon County was the principal theme of the meeting of the *Hunterdon County Medical Society* held at Clinton, N. J., on July 27, 1948. Under the chairmanship of the society's president, DR. E. D. MERRILL, the meeting heard an outline of the proposed hospital project, presented by DR. E. H. CORWIN, research secretary of the New York Academy of Medicine, who had been commissioned by the county Board of Agriculture to survey the needs and work out a plan. DR. RAYMOND GERMAIN, as chairman of the society's hospital committee, presented the report of his investigation into the organization of successful rural hospitals in other parts of the country and endorsed the project worked out by Dr. Corwin and the Board of Agriculture. The plan, in brief, calls for a 120 bed hospital to be built by local funds wth a federal assist under the Hill Burton act. There will be contractual affiliation with a top eastern medical school under which the university would nominate senior consultants to the hospital. The consultants would not enter private practice in the county, but would be available only on request of the family doctors. The University would furnish interns and residents. Staff appointments would be made available to all reputable Hunterdon county practitioners.

On motion of DR. A. J. BAMBARA, the society adopted a resolution endorsing, in principle, the plan proposed by the county Board of Agriculture and approved by the society's hospital committee. Provision was made for joint consultation on details of the hospital organization at the appropriate time.

The meeting was honored by the presence of DR. J. H. HORNBERGER, President of The Medical Society of New Jersey, who also took part in the discussion of hospital plans, and who characterized the proposal as an interesting and unique one which would bring even better health care to the people of Hunterdon. Dr. Hornberger raised several questions on organizational details which were attentively received and filed for discussion when joint consultations between the county Board and county Society are opened.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Robert B. Walker, President

Article II of our Constitution reads, "The purpose of the Auxiliary shall be to assist The Medical Society of New Jersey in such manner as it may suggest or approve". That purpose can be fulfilled in the privilege that the Medical Society has bestowed on us in asking the Auxiliary to assist in each county with the work of Health Week which will be held from November 8 to November 12.

Our sincerity and interest in the undertaking of this responsibility will help to further the security and stability of our record with those whom we serve. It is the duty, not only of the committee in each county auxiliary but of each member by their cooperation, energy and enthusiasm to lighten the burden of the busy physicians and thereby fulfill the purpose of our existence.

It would be pertinent at this time to ask ourselves this question, How much can I do toward Health Week in order to promote the welfare of mankind and encourage intelligent perspective toward medicine and in my community?

AUXILIARY PROGRAMS

Mrs. Thomas H. McGlade, Press and Publicity

Responses to a call for programs of the coming year were received from the following counties:

Bergen has used joint meetings of the husbands and wives and a family picnic as a means of becoming better acquainted and furthering the good will of the Auxiliary. We will hear more of their plans at a later date.

Camden will have the State president, Mrs. Robert B. Walker, and president-elect, Mrs. Norman Nathanson, as its guests at the opening meeting in October. A resume of Auxiliary work is to be given at this time, in the form of brief reports by each chairman. A combined public relations and legislative meeting will make November outstanding in Auxiliary events. New members are to be honored with a tea and musicale in February. A hobby meeting (limited to hobbies of the members only) is on the calendar for March and a luncheon meeting in May will bring to a close the Auxiliary year.

Hunterdon Auxiliary sponsored and served as hostesses at a picnic given for the members of the county medical society on Dr. Davidson's lawn on August 22.

Mercer plans for monthly meetings as regular business meetings together with these important events of the year: The Nurses' Scholarship Fund is to be benefited by a subscription dance in the fall. An open house lawn party will be held at the Medical Society Building in October. December 8, 1948—Auxiliary members will assist with the Fall Clinical Conference of the Medical Society. Groups of ten or more members are to be set up in each hospital, to take charge of registration, act as hostesses and guides to the visiting physicians. Members, driving cars, will aid in the transportation of the physicians from the station, to the hospital and from one hospital to another. The annual Christmas party is also planned for December. A public relations meeting will take place in April and finally the annual dinner-dance is to be held in May.

Passaic has invited the State president to bring greetings to their luncheon meeting in October, at which time, a talk on "Fabrics, the Way to Successful Decoration" will be presented. Members will hear a well-known authority on wills, at the January meeting. Dr. Dean Smiley will give a talk on "The Role of the Teacher in Health Education" at the March meeting. Mrs. R. J. McDonald is to have the members meet at her home in April and the annual luncheon completes the program for the year.

Salem stresses health education. They plan few, but informative and important meetings. October is to be devoted to the study of legislative material. Public relations is scheduled for January and March.

Somerset newly organized and no formulated plans—but responsive—our best wishes for a successful program.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **September, 1948** **No. 9**

The more rapid decline of the tuberculosis death rate in younger age groups and the gradual aging of the population have resulted in an increasing proportion of tuberculosis deaths in the ages over 45. Tuberculosis among older people is often unsuspected because the disease has long been considered the particular foe of youth. Although tuberculosis remains the leading cause of death from disease in the ages 15 to 35 the tuberculosis death rate increases steadily with age from a minimum in childhood to a maximum at 75 years of age.

TUBERCULOSIS IN THE OLDER AGE GROUP

The present practice of making extensive studies of tuberculosis in the younger age group of our population, thus minimizing the importance of the disease in the aged, has proved to be unwise.

The statement has been made that in persons over the age of 50 years the occurrence of communicable pulmonary tuberculosis is more frequent than in any other period. In 3000 routine postmortem examinations made at the Philadelphia General Hospital from 1936 to 1937, 11.2 per cent of the 1000 patients 60 years of age and over had died of tuberculosis. This and other evidence leaves little doubt that tuberculosis among older individuals is not rare.

The same irregular periods of activation and quiescence which are characteristic of tuberculosis occur in the older age group, and when continued, calcareous areas, fibrosis, fibrocaseous or fibrocavernous pathology finally develop. The disease among the elderly is usually of a chronic nature, and the patient continues with his occupation. One of the deficiencies in the control of tuberculosis is the failure to discover the disease in elderly individuals who may be spreaders of tuberculosis for many years.

A study of case histories of older patients having pulmonary tuberculosis gives the impression that the disease is usually acquired before 40 years of age though the time of onset is often difficult to determine.

Herewith are four illustrative cases:

Case 1.—A farmer at 28 years of age had a profuse hemorrhage, which was diagnosed as being of gastric origin. Six years later a daughter died of tuberculous meningitis. Fourteen years later, in an accident, he was badly exsanguinated. He recovered and continued his farm work for 22 years apparently in good health. At 70 years of age he complained of a productive cough and had a low grade fever. A sputum examination made at this time showed tubercle bacilli. Two years later, he died of tuberculosis. This man apparently had pulmonary tuberculosis for 44 years.

Case 2.—A female, married for 22 years, had been in poor health, but as no clinical symptoms were present to suggest serious trouble her family physician concluded that she was a malingerer and lost interest. Another doctor later found abnormalities in her chest upon physical examination and tubercle bacilli were present in her sputum. This woman, now 68 years of age, is still living.

Case 3.—A seven-year-old female died of pulmonary tuberculosis 22 years ago. The family consisted of two brothers, a father, and mother. During a school tuberculin-testing program held later the two brothers showed positive reactions. The mother was thought to be the source of infection, but her sputum examinations proved to be negative. The father failed to cooperate, claiming that he was in good health. Later he made a poor recovery from influenza, during which he lost weight and acquired a productive cough. An X-ray of his chest then showed far-advanced tuberculosis. He died of tuberculosis at the age of 80 years.

Case 4.—Forty-six years ago a young man, then 16 years of age, had three quarts of fluid aspirated from his chest. Fifteen years later rales were found in his right lung apex. During the next few years physical signs were found in both upper lobes. In 1933 an X-ray of his chest showed marked involvement of both upper lobes and this had progressed to cavity formation by 1946. This man, now 69 years of age, appears in excellent physical condition and in good health.

It seems unreasonable to assume that repeated exogenous reinfections account for the course of the disease in such cases. Many of these patients date the beginning of their trouble back to only a few months, while their X-ray indicates a long-standing disease finally reaching a stage where a breakdown occurs. Physical examination does not materially aid in making a diagnosis. Spinal deformities, ossification of the costal cartilages, and a decreased vital capacity are encountered in older patients. These alter the signs on inspection and palpation. Upon auscultation the findings are often confused by the presence of other pathologic conditions, namely, bronchitis, bronchiectasis, asthma, heart disease, and, particularly, emphysema. The X-ray film is the decisive factor in making a diagnosis in older as well as in younger persons. Neither a negative sputum examination nor a negative tuberculin test can rule out the disease.

These elderly patients present problems of segregation, individual education for their own and the public's safety, and their own personal treatment.

In the past 75 years persons over 50 years of age in the United States have increased from 3.8 to 5.7 per cent. The census of 1940 showed approximately 9,000,000 adults over 65 years of age. Should this increase in our old age population continue aged persons with tuberculosis must be given serious consideration to avoid the transmission of the disease from the aged to the young.

Tuberculosis in the Older Age Group, Charles D. Boyd, M.D., The Wisconsin Medical Journal, December, 1947.

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*Glafke, W. H.: Spastic Colon, M. Clin. North America 26:805 (May) 1942.

†Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1947, Philadelphia, J. P. Lippincott Company, 1947, p. 320.

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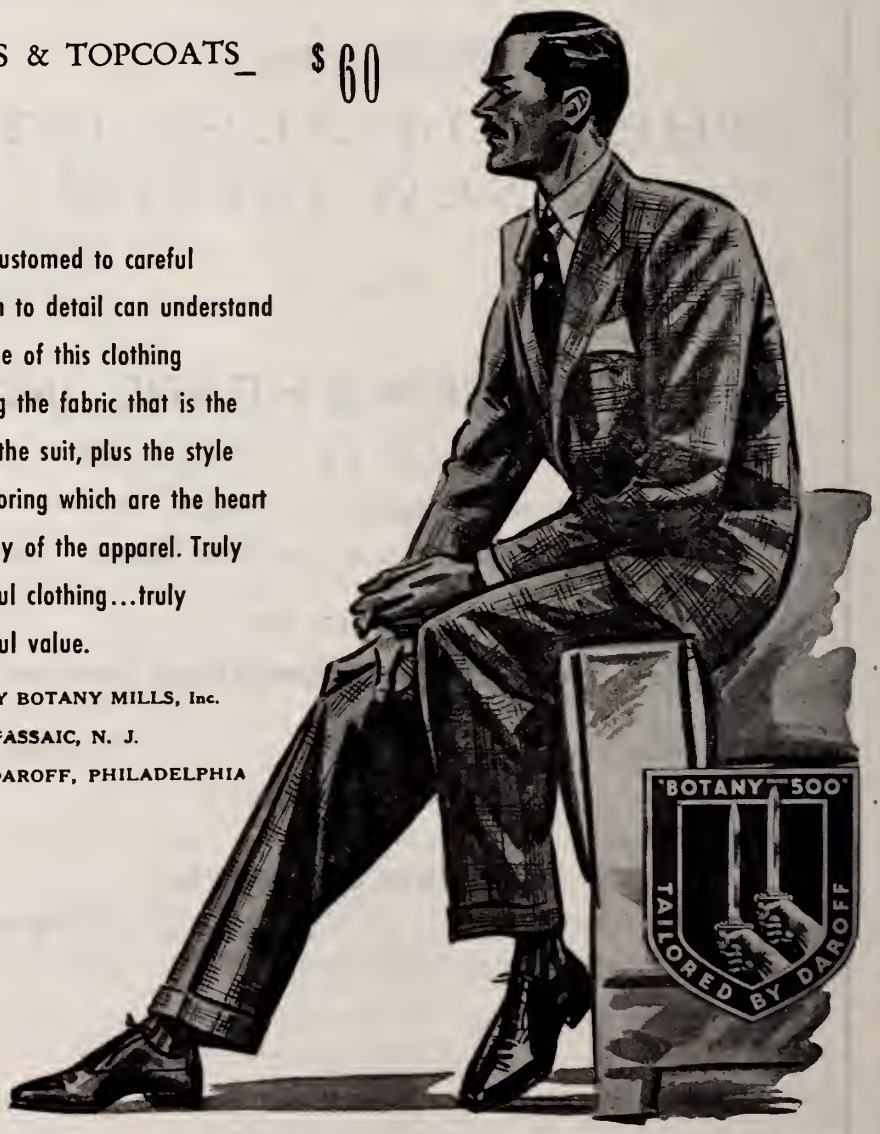
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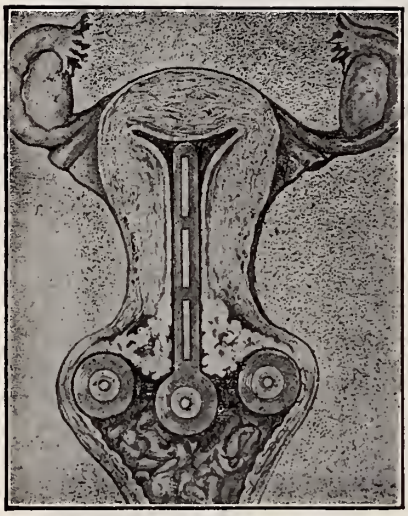
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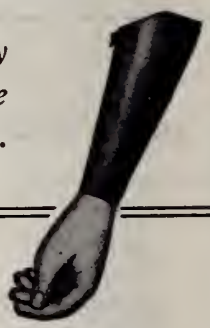


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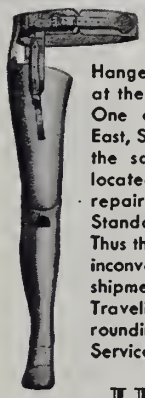
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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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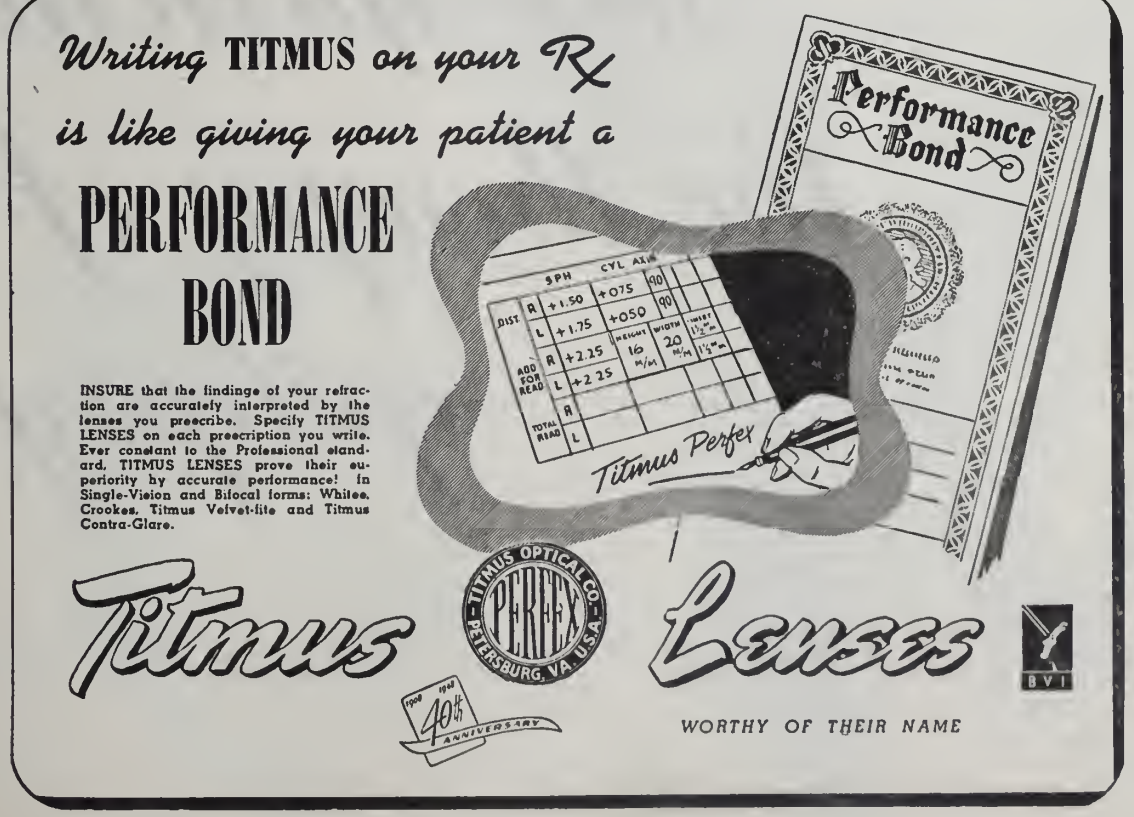
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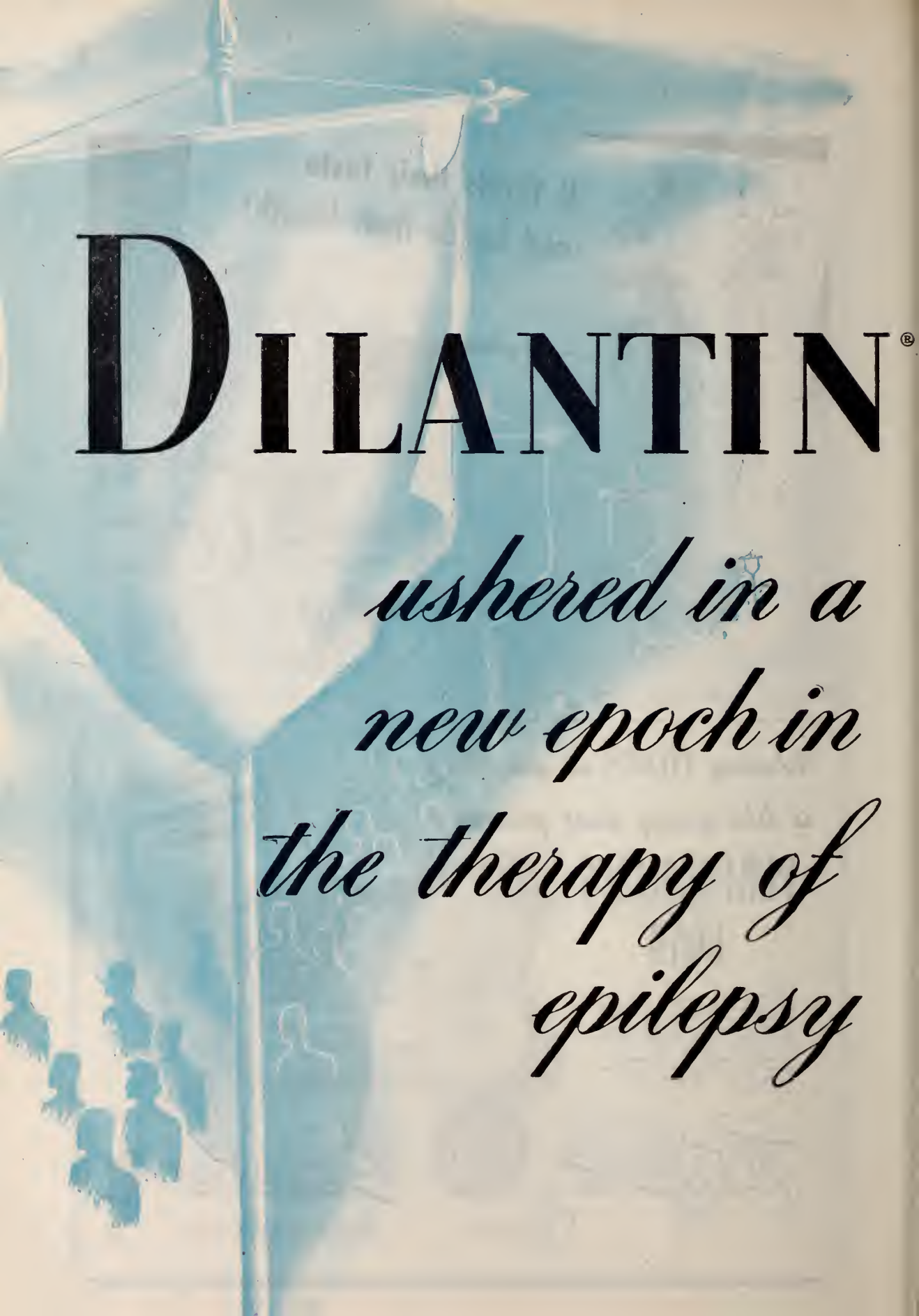
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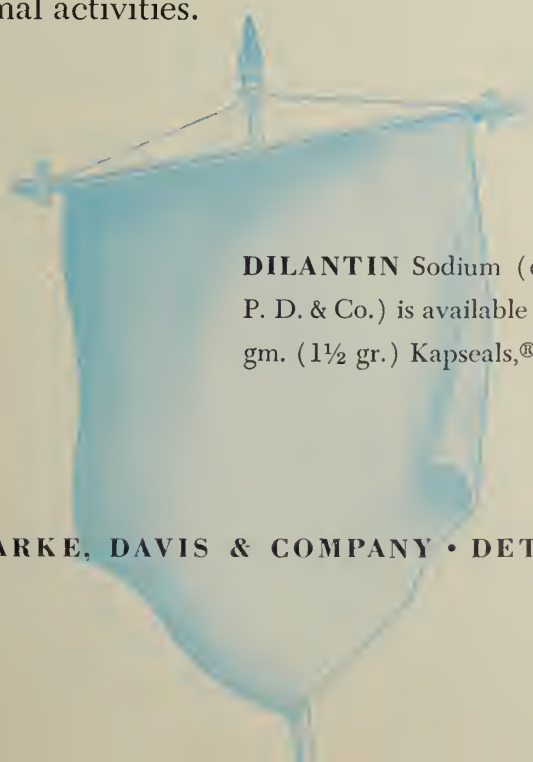

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50-60 . .	41	32	5	4
60-70 . .	34	22	8	4
70-80 . .	18	16	0	2
80- . .	3	3	0	0
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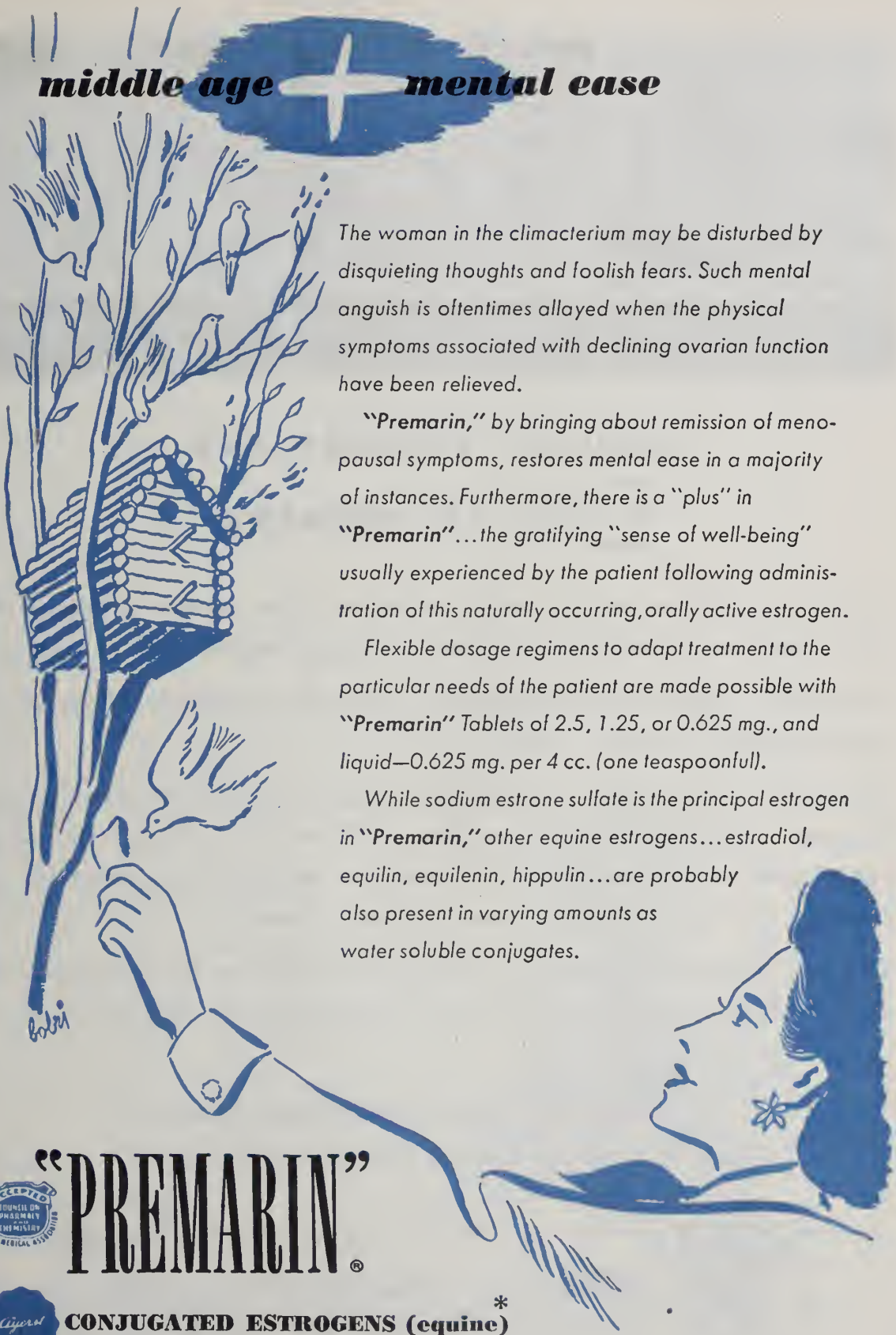
So it's easy to see why more and more physicians recommend Walker-Gordon Certified to their patients. They believe it's well worth a few pennies extra to get this marvelously pure milk with all its added nutritional values.

WALKER-GORDON CERTIFIED

THE WORLD'S FINEST MILK

For free illustrated booklet, write to Walker-Gordon, Plainsboro, N. J.

middle age + mental ease



The woman in the climacterium may be disturbed by disquieting thoughts and foolish fears. Such mental anguish is oftentimes allayed when the physical symptoms associated with declining ovarian function have been relieved.

*"**Premarin,**" by bringing about remission of menopausal symptoms, restores mental ease in a majority of instances. Furthermore, there is a "plus" in "**Premarin**"...the gratifying "sense of well-being" usually experienced by the patient following administration of this naturally occurring, orally active estrogen.*

*Flexible dosage regimens to adapt treatment to the particular needs of the patient are made possible with "**Premarin**" Tablets of 2.5, 1.25, or 0.625 mg., and liquid—0.625 mg. per 4 cc. (one teaspoonful).*

*While sodium estrone sulfate is the principal estrogen in "**Premarin,**" other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water soluble conjugates.*

ACCEPTED Council on Pharmacy and Chemistry American Medical Association

"PREMARIN"®

Ayerst

CONJUGATED ESTROGENS (equine)*

Ayerst, McKenna & Harrison Limited 22 East 40th Street, New York 16, New York

*Estrogenic Substances (water saluble) *also known as* Conjugated Estrogens (equine)

4818



1. Boil the water and cool to luke-warm



2. Float measured powder on top of the water



3. Mix with a large spoon or fork

SIMILAC FEEDINGS ARE Easy TO PREPARE

It takes only 30 seconds to induce solution *if the powder is floated on top of the water.* Lukewarm, boiled water is desirable.

No need to mix several ingredients—hence the possibility of errors in measurement is greatly reduced.

The ratios of fat, sugar, and protein, *and the zero curd tension,* remain constant regardless of concentration . . . Therefore, no gastrointestinal disturbance will normally occur, should the mother err occasionally in counting the number of measures of Similac powder.

The level tablespoon measure in each can eliminates the possibility of underfeeding or overfeeding due to varying sizes of "tablespoons."

Result: Similac reduces dietary disturbances traceable to mothers' errors in preparation of the formula

RESEARCH M&R NUTRITION SERVICE

SIMIL'AC . . . a dependable food during the all-important first year



ACCEPTED

M & R DIETETIC LABORATORIES, INC. • COLUMBUS 16, OHIO

Oral Penicillin "*even in serious infections . . .*"[1]

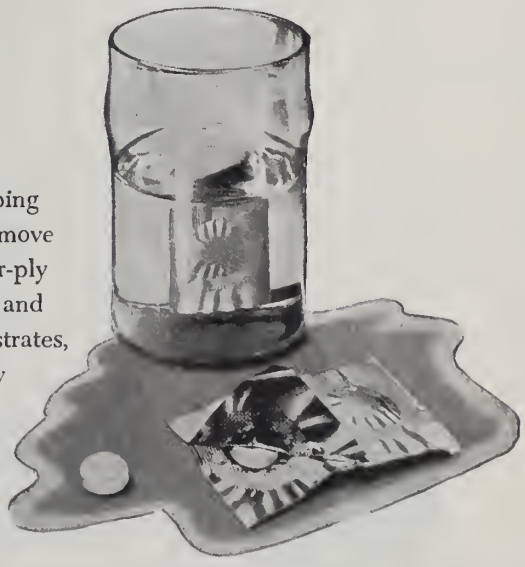
Used alone — not merely as adjuvant therapy — "orally administered penicillin is therapeutically successful even in serious infections, if a sufficiently high dose is given."[1]

By giving oral penicillin in doses of 100,000 units every 3 hours (often preceded by an initial "booster" dose of 200,000 units), clinicians have successfully treated pneumococcic lobar pneumonia, gonorrhea, and other infections, both acute and serious. Oral administration in high dosage produces penicillin serum concentrations within the antibacterial range of most susceptible pathogens. If prompt response is not obtained, parenteral treatment should be instituted immediately.

SQUIBB PENICILLIN TABLETS contain potent penicillin G for direct, active oral therapy. They are buffered for optimal absorption and are individually and hermetically sealed in a four-ply wrapping of cellulose acetate, pigment, aluminum foil and vinyl plastic to maintain full potency until administration. Tablets of 50,000 and 100,000 units, boxes of 12 and 100.

POTENCY SAFEGUARDED

Drop a Squibb Penicillin Tablet, wrapping and all, in a glass of water. When you remove it, and have wiped and taken off the four-ply wrapping, you will find the tablet whole and perfectly dry. As this simple test demonstrates, Squibb Penicillin Tablets are thoroughly sealed against penicillin-destroying moisture right up to the time of use.



1. Hoffman, W. S., and Volini, I. F.: Am. J. M. Sc. 213.520 (May) 1947

SQUIBB

CRYSTALLINE PENICILLIN G SODIUM (Buffered) TABLETS



WHEN *Anorexia* POSES SPECIAL PROBLEMS

Periods of anorexia following infectious disease and surgery can readily produce a series of consequences detrimental to the patient: (a) curtailed food consumption, (b) further deterioration of the nutritional state, and (c) impeded recovery.

When anorexia occurs, activation of food interest becomes a first consideration for rapid convalescence. Highly nutritious food which is at the same time tasteful, stimulative to the appetite, and easily digestible, thus possesses both a dietary and a therapeutic worth.

In convalescence when appetite lags, the delightfully tasteful food drink made from Ovaltine and milk has particular usefulness for inciting food interest. It gives the patient a threefold combination of important dietary values: worth-while amounts of virtually all essential nutrients, easy digestibility, and appetizing tastefulness. Three glassfuls of Ovaltine daily can convert even a dietetically poor to fair food intake to full nutritional adequacy.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.



Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

EXPERIENCE IS THE BEST TEACHER...



Carlos Finlay (1833-1915)

proved it in public health

Carlos Finlay, of Cuba, a bacteriologist, believed that yellow fever was transmitted by the stegomyia mosquito. His original experiments did not provide definite proof of his theory. However, he continued his search in co-operation with Walter Reed and the Yellow Fever Commission. The work of the Commission finally proved that infected mosquitoes could transmit the fever. The public health preventive measures derived from these experiments were so successful that the fever in Cuba was under control within a year.

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.



Experience is the best teacher in cigarettes, too!

MILLIONS of smokers who have tried and compared many different brands of cigarettes have found that cool, mild, flavorful Camels suit them best.

Try Camels on your "T-Zone"—T for Taste, T for Throat. See how your taste enjoys the rich, full flavor of Camel's choice, properly aged, and expertly blended tobaccos. See if your throat doesn't welcome Camel's cool, cool mildness.

Yes! Try Camels and see for yourself why, with thousands and thousands of smokers, Camels are the "choice of experience."

. . .

According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

Three independent research organizations in a nationwide survey asked 113,597 doctors to name the cigarette they smoked. More doctors named Camel than any other brand.

WE GRATEFULLY ACKNOWLEDGE THE ADVICE AND CO-OPERATION OF MANY PHYSICIANS IN HELPING US TO PLAN AND SUPPLY

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MODERN TESTED DIAPER SUPPLY

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FOR CUSTOMERS' *EXCLUSIVE* USE

Washed separately, dried separately, packed separately.

- The container furnished for used diapers while in the home sprinkles contents with an efficient antiseptic solution.
- All operations are carefully checked both chemically and by running regular bacteria colony counts on the diapers.

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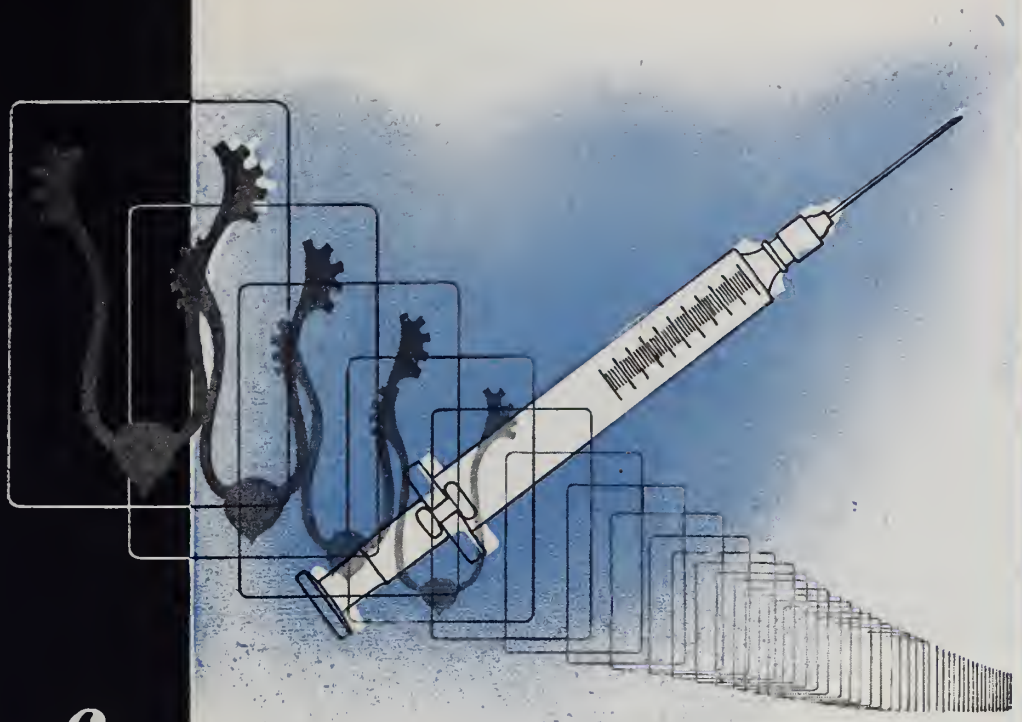
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Safe for injection

The safety record of NEO-IOPAX* — Schering's brand of sodium iodomethamate for intravenous urography — is noteworthy: more than fifteen years of effective urinary tract visualization *without a single fatality* reported in the literature. The relative safety of

NEO-IOPAX®

(*disodium N-methyl-3,5-diiodo-chelidamate*)

is due to its unique composition and stability, the meticulous care exercised in its preparation, the careful control of all manufacturing stages, and the rigorous inspection of the finished product. Each ampul of NEO-IOPAX is sterile and free from foreign particles.

NEO-IOPAX is available in 10, 20 and 30 cc. ampuls of 50% concentration and 10 and 20 cc. ampuls of 75% concentration. Packaged in boxes of 1, 5 and 20 ampuls.

*®

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NEO-IOPAX

SCHERING

Protein Nutrition

in later years

IN later years energy requirements are about 20% lower than in the prime of life. Because of this, a reduced food intake has definite benefit. All available evidence indicates that longevity is associated with body weight under the average of the population.

From a nutritional standpoint the optimum feeding regime for the aged should be a *calorically restricted* diet, which maintains *proteins at a good level.* A high-protein, low calorie diet helps prevent fat from becoming a burden to the vital functions of the aging body, and tends to maintain cell machinery in a good state of repair.*

Swift's Strained Meats
. . . when age presents problems
in protein supplementation

When age, disease or any injurious stimuli cause problems in protein supplementation, many physicians now prescribe Swift's Strained Meats. An excellent, palatable source of complete, high-quality proteins, Swift's Strained Meats provide *all* the essential amino acids *simultaneously*—for optimum protein synthesis.

Swift's Strained Meats supply goodly amounts of natural B vitamins, iron and trace minerals and are low in fat content.

Originally developed for infant feeding, these meats are strained fine—may easily be used in tube-feeding, or for oral feeding in soft diets. Since salt content of the meats is at a minimum for infants, additional salting is suggested for adult usage. Convenient—ready to heat and serve. Six kinds of Swift's Strained Meats: beef, lamb, pork, veal, liver and heart, provide variety and tempting meat flavors that help combat anorexia. 3½ ounces per tin.

SWIFT & COMPANY • CHICAGO 9, ILLINOIS



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All nutritional statements made in this advertisement are accepted by the American Medical Association's Council on Foods and Nutrition.

ALSO SWIFT'S DICED MEATS

—for high-protein diets requiring foods in a form less fine than strained, these tender, juicy pieces of meat are highly desirable.



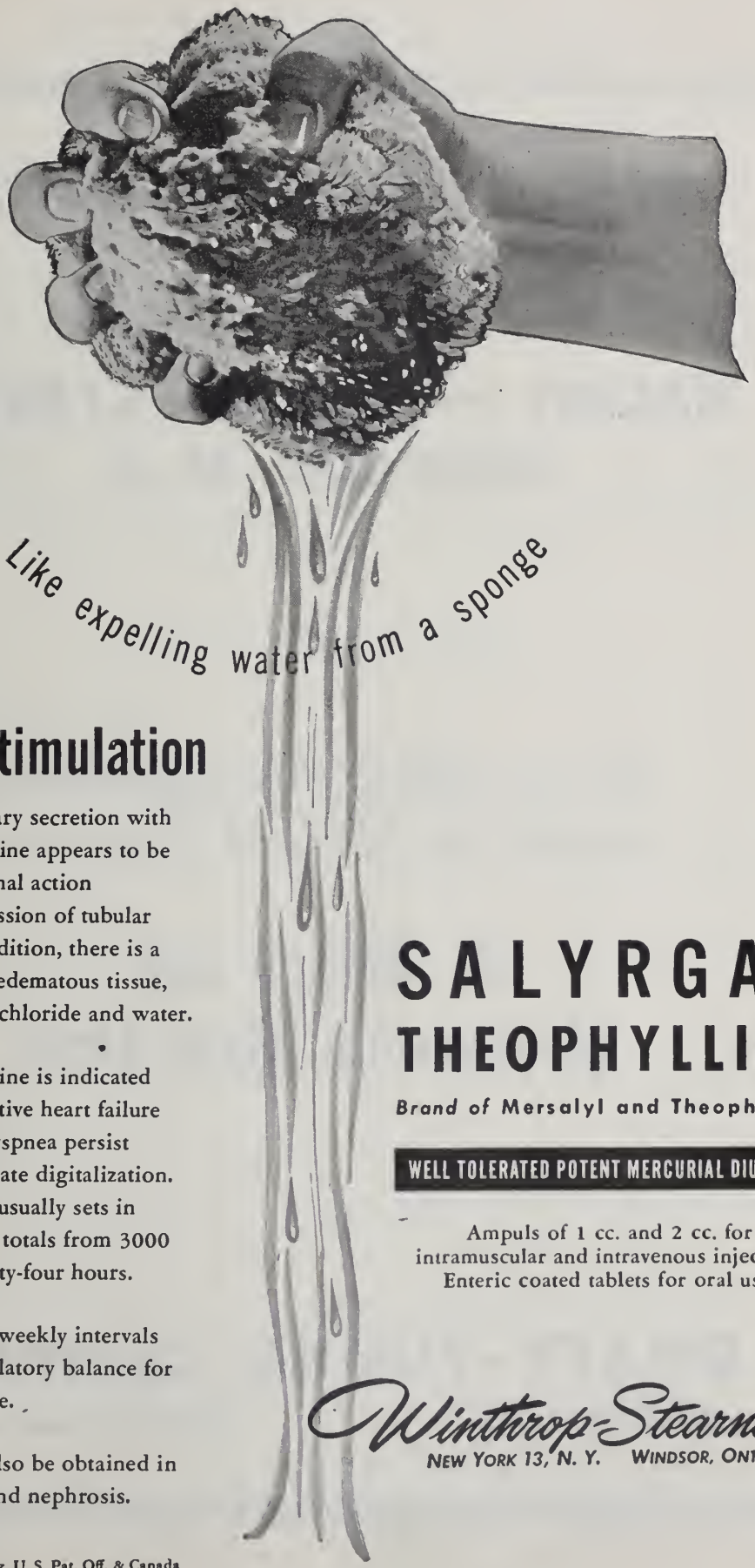
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Stimulation of urinary secretion with Salyrgan-Theophylline appears to be due chiefly to its renal action consisting of depression of tubular reabsorption. In addition, there is a direct influence on edematous tissue, mobilizing sodium chloride and water.

Salyrgan-Theophylline is indicated primarily in congestive heart failure when edema and dyspnea persist after rest and adequate digitalization. Gratifying diuresis usually sets in promptly and often totals from 3000 to 4000 cc. in twenty-four hours.

Injections at about weekly intervals help to insure circulatory balance for long periods of time.

Good results may also be obtained in chronic nephritis and nephrosis.

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Brand of Mersalyl and Theophylline

WELL TOLERATED POTENT MERCURIAL DIURETIC

Ampuls of 1 cc. and 2 cc. for intramuscular and intravenous injection. Enteric coated tablets for oral use.

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Its decontrol by the government has given the physician much relief.

There is now no restriction on its purchase nor as to how it may be prescribed.

Quinidine Sulfate Tablets (Davies, Rose)

0.2 Gram (approx. 3 grains)

are now readily available

These tablets
are made from the natural salt
are alkaloidally assayed and standardized
insuring accuracy and therapeutic dependability.

Each tablet is scored to permit divided dosage and bears the letters DR as a means of identification.

Kindly write "Davies, Rose" when prescribing these tablets.

Tablets of Quinidine Sulfate 0.12 Gram (approx 2 grains) and 0.3 Gram (approx. 5 grains) are also available, but the 0.2 Gram (approx. 3 grains) are supplied unless otherwise specified.

Davies, Rose & Company, Limited

Pharmaceutical Manufacturers

Boston 18, Massachusetts, U.S.A.

Qt

To The General Practitioner . . .

A Definition for your Patient who has a possible Ocular Involvement

Some patients may wonder about medical words. Suppose that you have told a patient that he should have an eye check-up. You wish him to see a medical eye specialist, but his vocabulary is confused. To eliminate such confusion, suggest that he see an Eye Physician (M.D.)

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Guild of Prescription Opticians of New Jersey, Inc.

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most highly regarded

OFFER a child candy—and he eagerly accepts it. Offer a sick child Penicillin *Dulcet* Tablets—and he eagerly accepts these. The reason is simple: he thinks they are candy. Penicillin *Dulcet* Tablets look and taste like candy, even when chewed or used as troches. A special cinnamon-flavored sugar base effectively covers the bitterness of the penicillin . . . 50,000 units of crystalline penicillin G potassium, which each tablet contains along with 0.25 Gm. calcium carbonate as a buffer. Penicillin *Dulcet* Tablets are a most practical form of oral penicillin for children, and also for those adults who dislike ordinary tablet forms. On your next prescription consider the sound therapy, the ease of administration, the ready acceptance —*then* specify Penicillin *Dulcet* Tablets, available in bottles of 12 at pharmacies everywhere. ABBOTT LABORATORIES, North Chicago, Illinois.

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Dulcet® Penicillin

Potassium Tablets (buffered)

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Airplane view of Nestlé's Dennington factory, Victoria, Australia



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A success in infant feeding 'round the world



Strategically located plants and a network of distribution facilities supply the people of Australia, Tasmania and New Zealand with Nestlé's milk products.

During the past 80 years Nestlé's has worked closely with the medical profession to develop quality milk foods for babies . . . and has met each advance in scientific knowledge of infant feeding with a corresponding improvement in product.

No wonder, then, that for more than three generations Nestlé's milk products have been best known and most used for babies 'round the world.

The record shows that Nestlé's was the *first* evaporated milk fortified with 400 U.S.P. units of genuine Vitamin D_3 per pint. The quality of Nestlé's Milk is assured every step of the way . . . we even take the plant apart every day and wash it!

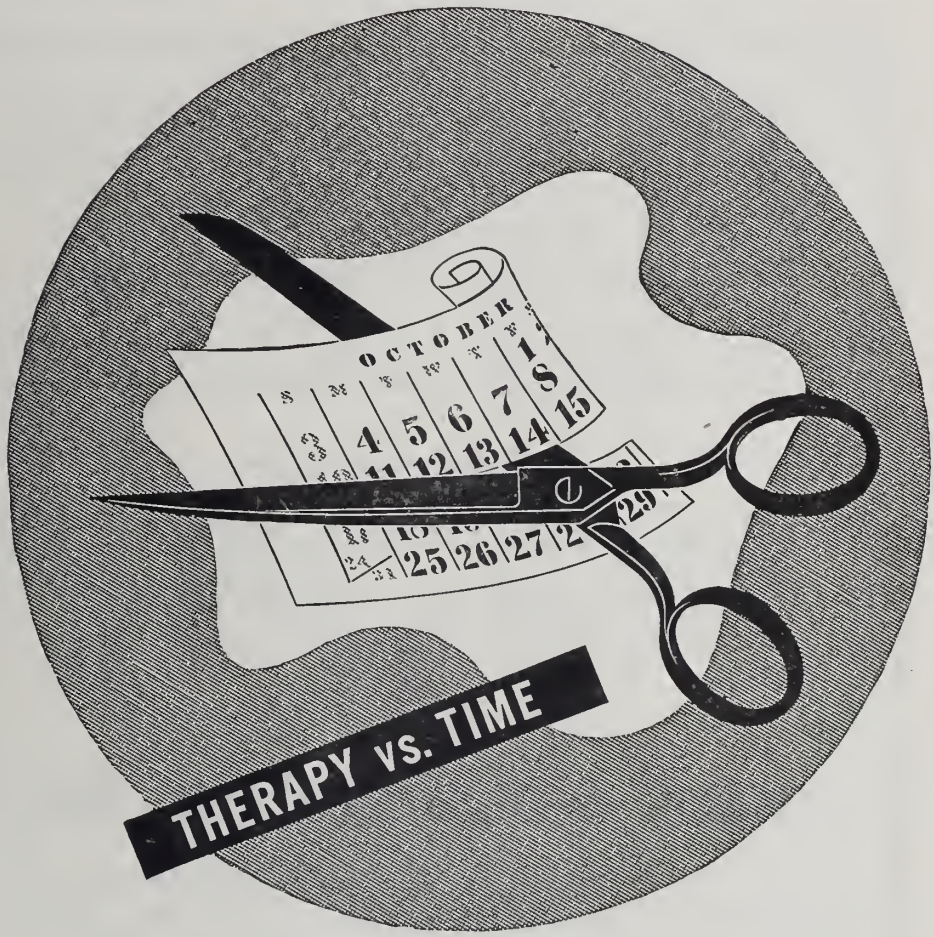
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The sooner the treatment of adrenal cortical insufficiency is initiated, the shorter may be the period of convalescence and the milder the patient's disabilities.

And the closer the therapy comes to replacing the multiple action of the whole cortical hormone, the more effective it can be.

Therein lies the therapeutic excellence of ADRENAL CORTEX EXTRACT (UPJOHN)—it is a specially extracted preparation from the whole gland containing the multiple active principles of the cortex. Whenever such typical symptoms of cortical insufficiency as lassitude, lowered muscular tone, markedly reduced resistance to infections, loss of weight, depression and mental apathy call for hormone replacement, ADRENAL CORTEX EXTRACT (UPJOHN) conveys in fullest possible measure the requisite cortical principles.

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since 1886

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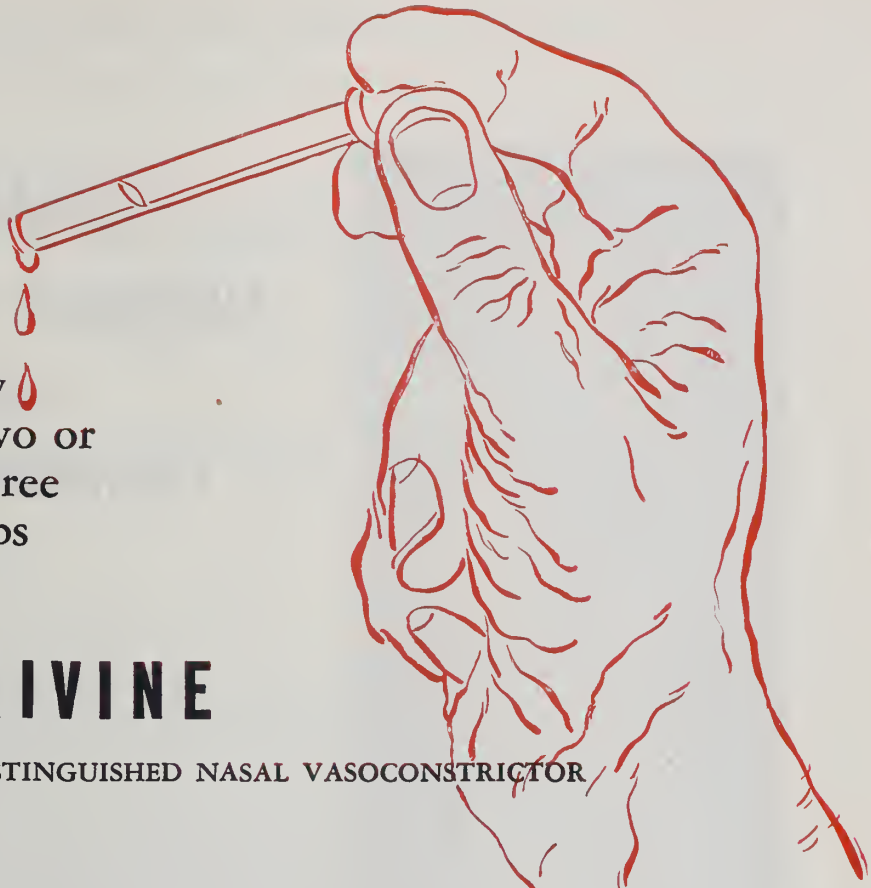
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only
two or
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high potency Only two or three drops of the 0.05 per cent solution of Privine hydrochloride usually give prompt and complete relief of nasal congestion and hypersecretion.

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Privine 0.05 per cent for all prescription purposes; 0.1 per cent strength reserved for office procedures.

Ciba

PRIVINE (brand of naphazoline) Trade Mark Reg. U.S. Pat. Off.



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ANATOMICAL SUPPORTS for NEPHROPTOSIS

Together with treatment for any existing infection of the urinary tract, Camp Supports have proven valuable adjuncts in the relief of symptoms in many cases.

Camp-trained fitters have been instructed to consult the physician as to the position required for the fitting, if reclining or partial Trendelenburg. In the event that the physician desires the use of a pad, the fitter has been instructed to obtain information as to the type of pad to be used and to ask the doctor to mark on the garment or blue pencil upon the patient the exact location of the pad.

Advantages of Camp Supports in Conditions of Nephroptosis:

1. The "lifting" power of Camp Supports is from below upward and backward.
2. Camp Supports are an aid in improving the faulty posture that sometimes accompanies renal mobility.
3. Camp Supports are easily and quickly adjusted.
4. Camp Supports stay down on the body by reason of the foundation laid about the pelvis.
5. Camp Supports are comfortable.
6. Camp Supports are economically priced.

Camp fitters ask patients to return to their physicians for approval of the fitting.

S. H. CAMP AND COMPANY • JACKSON, MICHIGAN

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We have found that our new surroundings and our new fixtures have been a good influence on our entire staff. Our orthopedic man, Mr. Kulka, has been working longer hours to keep up with his orders. All our other help work more efficiently; we all feel better. New things, furniture, machines, equipment might do the same for you. Patients notice new things in the doctor's office. Our Optical Department, under the supervision of Jess Wasserman & Co., Guild Opticians, are quite busy, too. I didn't know that so many people needed their glasses adjusted. Have yours adjusted the next time you come in.

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AMERICAN MEDICAL ASSOCIATION

Caminoids

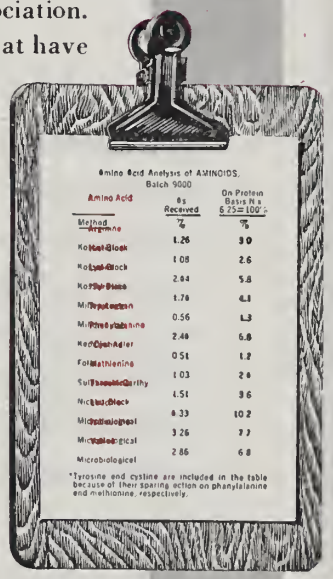
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BRAND OF AMINOPEPTODRATE

NEW NAME FOR A TOP FAVORITE IN PROTEIN NUTRITION

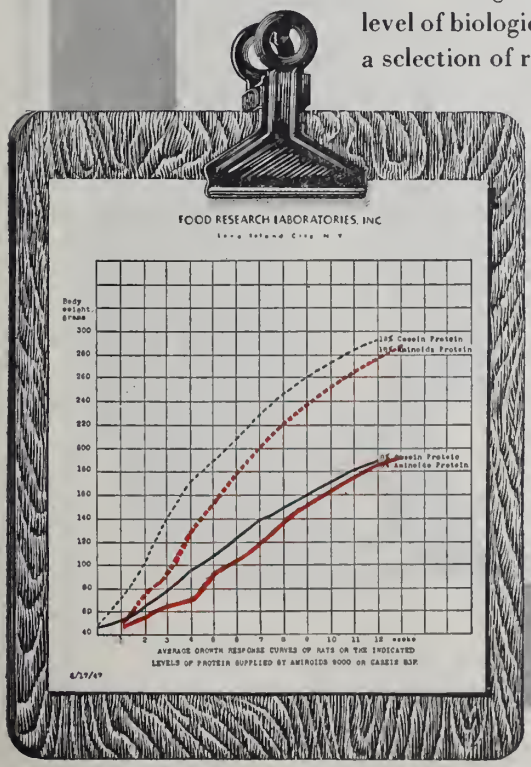
CAMINOIDS* is the new designation of Aminoids adopted as a condition of acceptance by the Council on Pharmacy and Chemistry of the American Medical Association. **CAMINOIDS** retains all of the "stand-out" qualities that have made Aminoids a protein supplement of choice:

HIGH PALATABILITY
HIGH BIOLOGICAL EFFICIENCY
HIGH PATIENT-ACCEPTANCE


Amino Acid Analysis of AMINOIDS, Batch 9000

Amino Acid	Gs Received	On Protein Basis N x 6.25=100
	%	%
Arginine	1.26	3.0
Histidine	1.08	2.6
Lysine	2.84	5.8
Tryptophane	1.76	4.1
Phenylalanine	0.56	1.3
Leucine	2.46	6.8
Isoleucine	0.51	1.2
Methionine	1.03	2.6
Threonine	1.51	3.6
Valine	4.33	10.2
Microbiological	3.26	7.7
Microbiological	2.86	6.8

*Tyrosine and cystine are included in the table because of their sparing action on phenylalanine and methionine, respectively.



Level of biological activity. Derived from a selection of rich protein sources: liver, beef muscle, wheat, soya, yeast, casein, and lactalbumin.

SUPPLIED: Bottles containing 6 oz.

No change has been made in the product. Your patients may continue to receive bottles labeled Aminoids until druggists' present stocks are exhausted.

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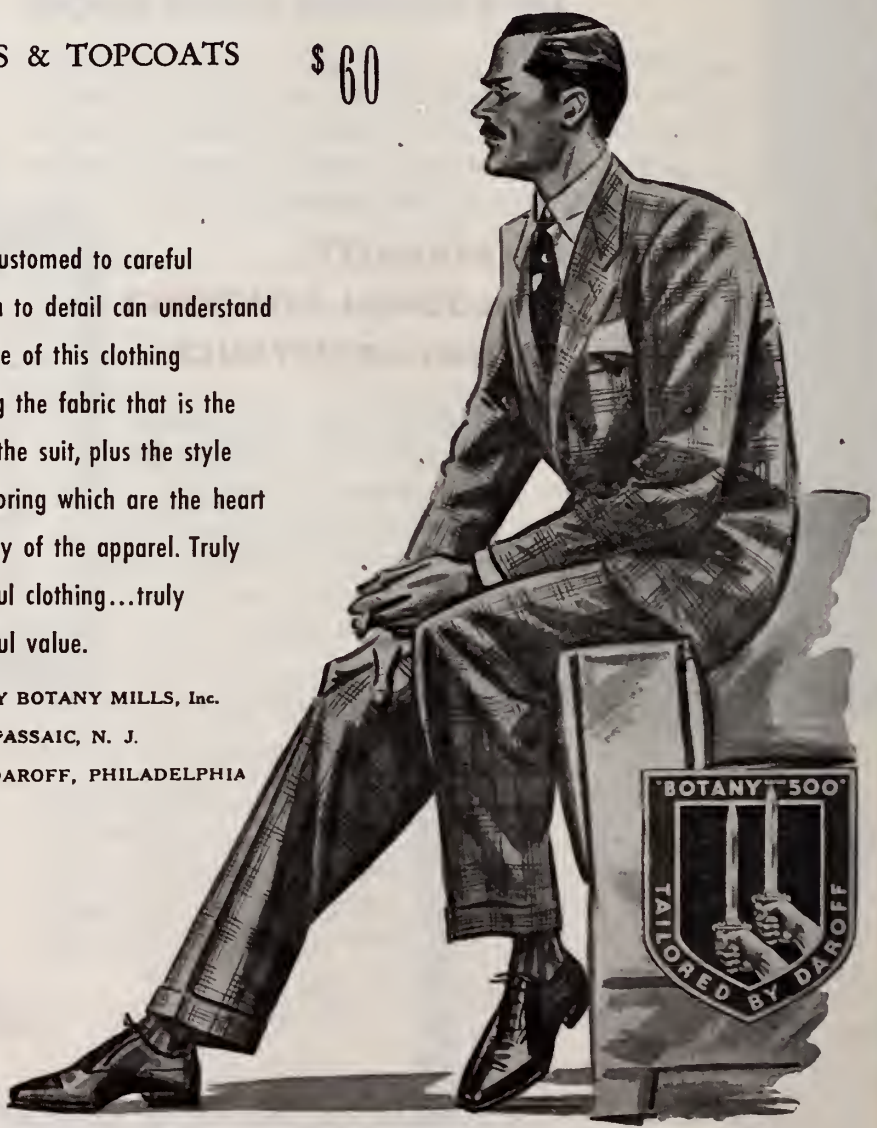
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BRAZIL was discovered and colonized by the Portuguese. Later, besides the Portuguese, came large numbers of other Europeans, notably Italians and Germans. Portuguese, however, is the official and only language of the country. The *Physician's Bulletin,* as well as labels and literature, is printed in Portuguese to serve over 12,000 Brazilian physicians. The first Lilly representative, with headquarters in Rio de Janeiro, began his calls on the medical profession in 1933. In 1945, the Lilly Branch was established, and as soon as suitable facilities are available Lilly products will be manufactured within the country. Here, as elsewhere in the world, Lilly scientists will work closely with physicians, assisting them in the development and clinical evaluation of newer medication. Practical applications of these researches will be made available to the medical profession wherever ethical pharmaceutical and biological products are sold.

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PRESIDENT'S MESSAGE

"ROUND-THE-CLOCK" MEDICAL SERVICE —THE DOCTOR'S RESPONSIBILITY—

Time was when nearly every physician's office was in his home. Except when he went out of town, the old time physician almost never got away from his work. Then too, in the "old days," a larger proportion of us were general practitioners, relatively few confining their practices to a limited field.—And, we didn't all try to take the same "day off" each week!

Our patients, also, were different. They didn't move around so much. Most of them had deep roots in their neighborhood, and one of these roots was attached to the "family doctor"—invariably, a general practitioner of medicine.

Today—when many physicians' homes are remote from their offices; when a high proportion of them (at least, in the larger communities) are specializing; when patients, generally, are more nomadic, and when many people have no family physician — new problems have arisen.

One of the most troublesome, and—from the standpoint of our public relations—most delicate problems is that of assuring every potential patient a ready access to the services of a general practitioner when a personal or family emergency occurs.

Everywhere in the nation there is a growing demand for the medical profession to set up organized facilities to handle emergency calls. The public feels that it is our collective responsibility to make medical service readily available when a person is unable to reach his family doctor in an emergency, or if he has no recognized family physician. On too many occasions, some of our patients have had a bad time of it trying to locate a doctor, and their reactions make unhappy copy in the public prints.

As a newspaper editor remarked recently to a group of physicians:

"You can ignore this public criticism if you want to. But in failing to solve this problem, in refusing to correct this complaint, you strengthen the hand of the advocates of state medicine who are not above telling people that it would enable them to get a doctor at any hour and on the flimsiest of excuses."

The Medical Society of New Jersey is alive to this problem and has requested each county society to study and solve the problem within its own jurisdiction. We have set up a clearing house of information on methods and plans used elsewhere in meeting this need.

This is, indeed, our collective responsibility. It is the *individual* responsibility of every member to see to it that a workable plan is set up in his community, and to do his part in making the plan work.

J. HOWARD HORNBERGER, M.D.,
President.

THOSE NINETEEN FATAL PRESCRIPTIONS

During the first half of the year, nineteen of our fellow Jerseyites died from barbiturate overdosage. Perhaps a few of these persons bought the drug in some distant state where a barbiturate law is not in effect. This, however, cannot account for more than two or three cases. All the other victims died by taking a medicine for which some physician wrote an Rx. Though we may be legally clear, we cannot as doctors, escape moral responsibility for these tragedies. But we can alert ourselves to the danger and consider what control methods we can adopt for ourselves.

Of the nineteen deaths, six were listed as accidental, the others as suicidal. Many of the patients for whom we prescribe sedatives are, of course, unstable and depressed. Let it be remembered that depressed persons are exactly the ones most prone to contemplate suicide. And unstable patients are often irresponsibly careless in measuring dosage.

Sedatives may deepen the depression in an agitated or worried patient. Thus we ought to do a double check on our judgment before we prescribe any sedative for a patient who is already depressed. If it is our considered opinion that barbiturates are indicated, we should call for small quantities only. Ideally, the aggregate quantity called for in this "non-repeat" prescription, should be under the lethal dose.

The minimum fatal dose of the various barbiturates is not established, but we do know that taking ten or twelve average doses at a time can cause a prolonged sleep which, if not interrupted, will lead to death. The conscientious practitioner would not want to write for more than a dozen doses on a single prescription if he is dealing with an unstable or depressed patient—and he often is. He can make special arrangements for the personal renewal of the prescription without charging an extra office fee each time. Better, certainly, to do that than to run the risk of causing death.

Some physicians, we are told, are very casual about writing for a hundred phenobarbital tablets or a pint of the elixir at a time. This is done with the best of motives: to save the patient the trouble and expense of too frequent returns to the office. However, it places in a private medicine chest a poison which can give painless death to any member of the family who, in a moment of moodiness, impulsively looks for this easy solution to his problems. And it is a reckless invitation to any careless self-dosing hypochondriac.

It is sobering to remember that the prescription we hand the patient may be a ticket to death as well as a passport to a healthier life.

ORIGINAL ARTICLES

SURGERY IN THE NEWBORN

Charles H. Evans, M.D., East Orange, N. J.

This is "the century of the child". The obstetrician and his ally, the pediatrician, have accomplished wonders in lowering the number of stillbirths and reducing the death rate in infancy and childhood. Deaths in children up to four years have been reduced 60 per cent in the past eighteen years; 47 per cent in infants under one year and about 30 per cent in the neonatal period or during the first month of life. The decrease is still relatively small during the first weeks of life.

In 1945 the death rate for infants under one month of age was 24.3 per 1000 live births, or 63.4 per cent of the total mortality occurring during the first year of life. The majority of these deaths occur in the first two weeks of life, and many of them are due to an abnormality or disease which could have been successfully treated surgically. We will be called to treat a greater number of these babies; approximately 3,000,000 children are born annually in the United States, and hospital deliveries have risen from 37 per cent to 79 per cent in the last decade.

The autopsy of a stillbirth or newborn infant is not legally required, nor is it popular except in a few of our large children's clinics. If we hope further to reduce the number of stillbirths and deaths in the first few weeks of life (when the greatest number occur), we must see that competent pathologists tell us just why these babies die. We will also find that "atelectasis" is seldom, if ever, a cause of death, and the term "prematurity" will be used less and less to denote the cause of death in these babies. Potter[1] reports that "prematurity" was listed only half as often as the cause of death in hospitals where the fetus and newborn are autopsied; that "atelectasis" is not a cause of death but a symptom of underlying abnormality. She examined the bodies of 2000 stillborns or infants who died in the first month of life. Over 10 per cent had abnormalities which were incompatible with life. In 8 per cent the malformation was in the gastrointestinal tract. Malformations were more common in infants born alive and at term than in stillbirths or prematures. Dunham[2] tells us that "The neonatal period is one of great danger to the infant as well as one about which too little is known".

In an analysis of the original case reports of 1402 cases of intestinal atresia (excluding the esophagus and recto-anal regions), I was amazed at the number of cases in which a second or third type of congenital intestinal obstruction was associated with atresia. This helps to explain why many cases of congenital hypertrophic pyloric stenosis, imperforate anus, omphalocele, or volvulus, have died with an intestinal obstruction, after a satisfactory correction of the anomaly. There were in this series of intestinal atresias the following associated abnormalities:

14 with atresia of the esophagus.
9 with congenital hypertrophic pyloric stenosis.
29 with an annular pancreas (here the pancreas completely surrounded the duodenum and in many cases there was a gap with pancreatic tissue between the blind ends of the duodenum).
23 of atresia or other abnormalities of the bile ducts.
76 of volvulus of the small intestine.
9 of intussusception.
55 with an omphalocele or umbilical fistula of omphalomesenteric duct origin.
114 cases of an imperforate anus or an atresia of the rectum.

In four of the cases with an omphalocele, the small bowel ended blindly in the sac and could plainly be seen through the transparent wall of the persistent physiologic umbilical hernia.

1. Potter, Edith: Journal of the American Medical Association, 115:996 (1940) and also, American Journal of Clinical Pathology, 13:133 (1943).
2. Dunham, Ethel: *Appraisal of the Newborn.* U. S. Children's Bureau Publication No. 242. Government Printing Office, Washington, D. C. (1947).

One was a child upon whom I recently performed an emergency ileostomy on the first day of life; on the fourth day a successful "subperitoneal" side-to-side ileo-ileocecostomy was done between the contiguous loops several centimeters from where they passed through the abdominal wall to form the double-barrelled ileostomy.

CLAMPING THE CORD

I stress the importance of *not* clamping the cord until approximately ten minutes after delivery, or until the placenta separates. This is essential in the premature, or in any infant who has an acute illness or operation during the first months of life. Engel [3] reports that the mortality is twice as high in prematures whose cords are clamped immediately after birth. One-fourth of the total fetal blood is in the placental circulation. The more premature the infant, the higher the ratio of placental blood. The principal iron reserve in the newborn is in the circulating blood; as much as 54 milligrams of this iron may be lost if the cord is clamped immediately after birth. This loss is enough to lower the hemoglobin in a four months old child from 12 to 9 grams, or from 70 to 58 per cent.

Many newborns have been subjected to an acute hemorrhage when from 100 to 200 cubic centimeters of blood have been recovered from the cord blood to build up a "blood bank". If this blood is not drained off and the cord is not clamped until it has collapsed, about half the placental blood will flow into the infant during the first minutes after birth and 90 per cent will have been recovered at the end of ten minutes. The hemoglobin and red cell count are about 10 per cent higher in the week-old newborn whose cord is not clamped until after the placenta has separated. We will patiently wait these few minutes when we realize that this preventable cord hemorrhage, added to the normal physiologic anemia following birth, makes the infant a poorer medical and surgical risk than the infant who has not been robbed of his placental blood or has had time normally to correct these anemias.

INTUSSUSCEPTION

Intestinal intussusception is a serious pediatric and surgical problem. As you well know, it is probably the most common cause of acute intestinal obstruction in late infancy. The clinical picture is typical and few of these cases are missed when examined. The mortality continues to be very high regardless of the type of treatment. This high mortality is due to two major causes: (1) Many such children, after several intermittent attacks of colic, quickly become critically ill and have a gangrenous bowel or irreducible intussusception before the mother realizes the gravity of the condition and calls her physician. (2) Intestinal surgery in the infant, especially the infant with a non-viable loop of bowel, is more difficult to perform, more dangerous, and requires a more exacting and prolonged after-care than is the case in the older child or the adult.

Simple reduction, with or without laparotomy, has failed to save many of these simply treated cases. The usual operative procedures in cases with gangrenous or irreducible lesions are either a primary enteroanastomosis with or without resection, or the Mikulicz multiple stage resection. The mortality ranges from 25 to 75 per cent. The Mikulicz exteriorization procedure is apparently the safer of the two operations.

There is soon to be reported in more detail a type of "subperitoneal" lateral anastomosis placed near the emerging proximal and distal limbs of an emergency ileostomy performed several days before. Two cases of total atresia of the ileum in newborns have been successfully treated in this manner. I believe that this operation,[4] which I have not been able to find reported in the available medical literature, will prove to be a rational surgical procedure not only in atresias of the newborn, but also in intussusception, volvulus, or other forms of intestinal obstruction where the bowel at the obstructed point is non-viable and the patient unable to survive a primary resection or the loss (over periods of weeks to months)

3. Engel, D., cited by Windle, W. F.: In the Journal of Pediatrics, 18:538 (1941).

4. These cases and the operative technic employed were reported by the writer in a paper, *Diagnosis of Intestinal Obstruction in Infancy*, delivered at the May 26, 1948, meeting of the Society of Surgeons of New Jersey, held at the Orange Memorial Hospital, Orange, N. J.

of succus entericus through the artificial anus and then through the fecal fistula, which are associated with the Mikulicz type of resection.

ACUTE APPENDICITIS

Acute appendicitis in the newborn and infant is more common than realized by many physicians. I have collected a thousand cases which occurred in the first year of life. Too frequently the condition is not even considered, or the operation is done when it is too late. The diagnosis is seldom made except at autopsy. In this age group, the disease is usually rapid, and rupture with peritonitis is frequently the case. The clinical picture is almost always atypical and very confusing. How well we remember Dr. Holt's remark: "In acute appendicitis in the infant, all signs fail us".

Think of appendicitis as one of the possibilities when examining an infant who, following a mild fever and upset stomach, suddenly presents the picture of an acute surgical abdomen. Penberthy [5] and his associates found 20 cases in infants among 1655 cases operated upon during the first twelve years of life.

The greater frequency in the male infant is probably more apparent than real. Ten per cent of cases of hernial appendicitis (a condition usually seen in late adult life where there is an acute appendix lying in a large hernia sac) are found in male infants during the first year of life. In about 20 per cent of all cases of appendicitis in infancy the appendix, usually gangrenous and ruptured, was located in the sac of a congenital inguinal hernia; in each case the pre-operative diagnosis was either a strangulated inguinal hernia or a suppurative orchitis.

DUODENAL ULCER

Duodenal ulcer in the first months of life is more unthought of and more unrecognized than uncommon. Schmidt [6] found 19 cases among 1100 autopsies of infants from five days to eleven months of age; Entz [7] reported 10 cases among 364 autopsies upon children under one year of age; Bartran [8] reported four cases seen in one year among 150 infants in one hospital.

A personal study of many hundred cases in the literature leads to the following conclusions:

(1) True duodenal ulcer occurs in the newborn and early infant periods; then becomes less common until adult life is reached.

(2) Very few have been operated upon; the diagnosis is usually made at autopsy; only several cases have been saved after perforation of the ulcer.

(3) Apparent food distress, blood in the stools, and in 40 per cent of cases blood in the vomitus associated with an increasing anemia, can be due to a bleeding gastric or duodenal ulcer.

(4) The case history and the x-ray studies, so important in the older child and adult, are of little help to us in these baby ulcer cases.

(5) We have no justification to explore each baby who shows some food distress, mild intestinal bleeding, an increasing anemia, and perhaps slight abdominal distention. *Yet we should keep the possibility of an ulcer in mind,* keep the blood, body water and electrolytes in balance, *and be ready to operate upon the occasional case which perforates* and quickly changes the picture to that of an acute surgical abdomen.

Then only will we be able to successfully treat this almost universally fatal intestinal accident.

CONCLUSION

I close the discussion with a few words from the late Dr. J. Shelton Horsley, who was one of our great physicians as well as a pioneer surgeon in this field.

Dr. Horsley, when speaking on duodenal atresia, said:

"Congenital intestinal obstruction has not received the attention it deserves. Too frequently a diagnosis is made either of a functional condition or of improper feeding, and different formulae are tried and various drugs administered until the baby dies. A necropsy is seldom done. Babies as well as adults die of real things, and rarely of functional disturbances. If physicians who attend babies will bear in mind the gravity of the symptoms of early vomiting and will not be content until the cause of the vomiting has been definitely ascertained, many babies that now die within the first few days of their lives, with vomiting as a chief symptom, can be saved."

5. Penberthy, G. C., Benson, C. D., and Willer, C. N.: Annals of Surgery, 115:945 (1942).
6. Schmidt, Walther: Berliner Klinische Wochenschrift, 50:593 (1913).
7. Entz, cited by Bartran, see reference number 8.
8. Bartran, W. H.: Journal of the National Proctologic Association, 18:77 (1946).

144 Harrison Street

SURGICAL ASPECTS OF CANCER OF THE LUNG*

HENRY A. BRODKIN, M.D., Newark, N. J.

Up to fifteen years ago, the diagnosis of cancer of the lung during life was ventured only by the more astute clinicians. Although such a patient aroused great clinical interest, the attitude as regards treatment was the same as for leukemia. Following the publication of Graham's first pneumonectomy, we went through a period of exploring patients who were found hopelessly inoperable. Gradually the profession became better acquainted with the earlier manifestations of the disease and more and more patients came to operation who could be successfully resected.

Today in spite of improvement in diagnostic methods and surgical technic we find one in every three patients who come to the hospital, obviously inoperable because of large pleural effusion, venacaval obstruction, erosion of ribs and distant metastasis. Another one in three is found inoperable because the lesion has extended into the heart, aorta parietal pleura or diaphragm. The third case is found resectable, but even here, the outlook for a surgical cure is poor because of the extent of involvement of the regional lymph glands. Whenever cancer has spread to regional lymph glands, prospects of a surgical cure are greatly diminished. In cancer of the breast when the disease is limited to that organ, over 70 per cent survive more than five years. When the axillary glands are involved the ratio drops to 35 per cent. Similarly, in pulmonary malignancy, our best results are in patients whose tumor is still a local lesion. It is, therefore, obvious that the results of the surgical treatment of cancer of the lung are very poor at the present time.

Why are patients with pulmonary malignancy referred so late to the surgeon so that only one in every three cases is resectable? The three major reasons for this are:

1. Onset of the disease is insidious and there are no characteristic or pathognomonic signs or symptoms. By time cough, pain in the chest, hemoptysis and loss of weight are present, the disease is well established.

2. Although the x-ray shows a positive shadow in almost every case, this procedure is delayed until every type of cough mixture has been ineffectively consumed. Even with positive x-ray evidence of a shadow in the lung field, too many physicians fail to follow through. Instead they lose valuable time to see what the next film will show.

3. A positive diagnosis can be made in 75 per cent of the cases by x-ray and bronchoscopy. In the remaining 25 per cent, because the diagnosis is obscured surgical treatment is postponed.

Early diagnosis will bring better results if we use the means to do it.

1. The x-ray is the most important diagnostic tool. It is imperative to x-ray every patient over 40 who presents symptoms of a cough lasting over two weeks, dull pain in the chest or blood stained sputum. This will show either the growth itself or the effects of it such as atelectasis, retrograde pneumonitis, abscess, etc.

2. Bronchoscopy is second in importance. A positive biopsy is obtainable in about 70 per cent of the cases of carcinoma of the lung. In peripheral or upper lobe carcinoma, it may be impossible to obtain a positive biopsy. However, by suction, a sputum specimen may be obtained for examination for cancer cells according to the Papanicolaou technic. This is proving to be more reliable by showing positive results in 80 to 90 per cent of carcinomas of the lung. It is of especial value in peripheral and upper lobe cancers. Tomography has also been very helpful. Bronchography is of limited value in the diagnosis of cancer of the lung. After these methods have been used, a small number will remain in which diagnosis is obscured and unconfirmed. In this type of case, it is imperative to perform an exploratory thoracotomy. Adoption of these principles will bring the case of cancer of the lung to surgical treatment at the earliest possible moment.

OPERABILITY

Patients with suspected but unconfirmed malignant tumors of the lung should be ex-

* Read by invitation at the International Congress of Cancerology, Havana, Cuba, May 3, 1948.

plored. All patients in whom a diagnosis of carcinoma of the lung has been made, (if no distant metastasis can be found) should have the benefit of exploratory thoracotomy. In some cases, successful resections have been accomplished although the lesions involved the pericardium and the chest wall. The involved part was resected with the lung. Although pleural fluid and phrenic paralysis are regarded as evidence of inoperability, successful resections have been reported. In 2034 patients with carcinoma of the lung reported by twelve leading clinics in the United States, only 29 per cent were explored and only 13 per cent were resected. Today, a greater proportion of the cases is explored and resected.

PRE-OPERATIVE MANAGEMENT

As soon as the decision for surgical treatment has been reached, the patient's general physical condition is brought to the highest level. Blood studies may indicate the necessity for transfusions to relieve the secondary anemia. High supplementary protein diets are added to raise the plasma protein level. Adequate vitamins are prescribed to relieve deficiency and improve healing qualities. Three days prior to operation, aerosol penicillin is administered three times a day. Thirty thousand units of penicillin are given, intramuscularly, every three hours during the waking period. Artificial pneumothorax, given prior to surgery, appears to be of benefit. This serves two purposes:

1. It will determine if the remaining lung can take over the entire burden of respiratory function. In one case following a successful pneumonectomy, the patient was cyanotic and anoxic. A preliminary pneumothorax would have suggested a lobectomy instead of a pneumonectomy which would have prolonged his life in greater comfort.

2. It appears to be less shocking to a patient to remove a collapsed lung than one that has been functioning.

ANESTHESIA

It is essential to have a trained anesthetist expert with endotracheal anesthesia who has had considerable experience with thoracic surgical cases. He must be well versed in cardio-respiratory physiology. He will advise the surgeon when to halt the operation, re-inflate the lung, aspirate the bronchial secretions, administer blood and medications as the patient's condition demands. The bronchial tree must be kept constantly free from excretions and mucus.

SURGICAL APPROACH

In carcinoma of the left lung, the anterior approach through the third interspace (with incision of the third and fourth costal cartilages at the sternum) is preferred. On the right side, the postero-lateral approach with resection of the fifth rib is used. The individual vessel ligation technic is employed. ligating the pulmonary artery first. The bronchus is treated by clamping below the site of the incision. The lumen is then occluded by two interrupted mattress silk sutures above and a row of interrupted silk sutures uniting the cut edge. An attempt is made to cover the bronchial stump with mediastinal pleura. The phrenic nerve is crushed. After the lung has been removed, the pleural cavity is irrigated with warm saline. The pleural surfaces are dusted with sulfanilamide powder. Two units of plasma and 200,000 units of penicillin are left in the pleural cavity. The negative pressure in the pleural cavity results in the accummulation of plasma and blood. The plasma helps counteract this. The wound is closed in layers without drainage. An important step at the conclusion of the operation is aspiration or bronchoscopy to remove mucus, blood or pus which may remain in the trachea or bronchus. The patient is placed in an oxygen tent for 24 hours. The next day this may be periodically discontinued and the patient permitted to sit up in bed. Ambulation is attempted on the second or third day. Prevent cardiac displacement or embarrassment of the contra-lateral lung by aspiration of some of the pleural contents of the operated side when indicated.

The most favorable form of carcinoma of the lung for surgical treatment is the peripheral type. This arises in the small bronchioles and can be seen and felt on the surface of the lung with a flattened or umbilicated center. This type is out of reach of the bronchoscope and can be adequately treated by a lobectomy rather than a pneumonectomy. If a positive bronchoscopic biopsy is obtained, a pneu-

monectomy rather than a lobectomy is indicated. One of my patients had a lesion confined to the right lower lobe with a positive bronchoscopic biopsy. The right lower and middle lobes were removed leaving the right upper lobe. In retrospect, I think that a pneumonectomy should have been done in this case. Within a year, this patient died of metastasis. As a general rule, the most effective way to treat any carcinoma, is to remove the entire organ with its regional lymph glands.

INOPERABLE CASES

No method of treatment now known will allay symptoms or prolong life in inoperable cancer of the lung. I had one patient who, a month from the day of his first symptom to his arrival in the hospital, was obviously inoperable; one month later, he was dead of his disease. On the other hand, another patient of mine, lived comfortably for two years, after a thoracotomy revealed the inoperable state of his pulmonary cancer. Neither had x-ray treatments.

In two types of "inoperable" cases, surgery may be of some value. One is the superior sulcus or Pancost tumor which is usually accompanied by severe pain in the shoulder girdle and arm. One such patient had been existing on morphine for months with scarcely any sleep. Excision of the involved ribs together with the corresponding intercostal nerves provided this patient with a comparatively painless six month interval until his death. The other is the type that ordinarily would have been regarded as inoperable because of neoplastic extension into the overlying ribs and breast. The entire left lung, the overlying chest wall and breast were removed en masse and the patient has been comfortable and well for the past five months.

CONCLUSION

Surgical treatment offers the only present hope of relief from cancer of the lung. Results are still poor because the patients arrive too late for relief. The future lies in the appreciation, by the medical profession, of the early manifestations of the disease and of the value of early surgical treatment.

365 Osborne Terrace

SENATOR SMITH — DR. MARTLAND — MR. O'HERN

Announcement is made of a three-star featured program of interest to all physicians, at the Academy of Medicine, on Saturday evening, October 23, in Newark (91 Lincoln Park).

Dr. Harrison S. Martland will speak on atomic medicine—"A Glimpse into the Future".

U. S. Senator H. Alexander Smith will discuss "Trends in Medical Legislation".

Mr. Joseph O'Hern, Manager, Newark Regional Office, Veterans Administration, will talk on the impact of the veterans hospitals on private medical practice.

This unique meeting is under the auspices of Physicians Post 445, Department of New Jersey, American Legion, and the occasion will be the installation of new officers for this all-medical post.

All members of The Medical Society of New Jersey are invited to attend.

MEETING OF PHYSICIAN-ARTISTS

Physicians interested in arts and crafts are invited to attend a special meeting at the Academy of Medicine, 91 Lincoln Park, Newark, Tuesday evening, October 12, at 8:30 p. m.

One function of this meeting will be to advance plans for developing a New Jersey Physician-Artists organization and to set a date for an exhibit of paintings, sculpture, photography and other forms of art expression by members of the medical brotherhood.

ULCERATIVE AND REGIONAL COLITIS *

J. F. PESSEL, M.D., Trenton, N. J.

Non-specific or idiopathic ulcerative colitis is an inflammatory, ulcerating disease of the large intestine, characterized by long periods of exacerbation and remissions. The cause of this disease has not been agreed upon. It often follows psychologic disturbances, acute bacillary dysentery, amebic dysentery, devastating disease and, rarely, mucous colitis. It tends to begin between the second and fourth decade of life, but cases have been observed much earlier. There are often evidences of emotional instability and pre-existing autonomic imbalance in individuals suffering from this disease.

ETIOLOGY

Often the first, as well as recurrent attacks are accentuated or produced by psychogenic upset:—loss of a member of the family, business reverses, frustrations in love affairs, serious family difficulties, or disturbing, acute infections. Many chronic cases seem to become sensitized to food proteins, a fact which leads some physicians to look for allergic factors. Felsen [1] feels that it most frequently follows bacillary dysentery. Bargen [2] thought that it was due to a diplo-streptococcus. Graduate students from Central and South America, who see a great deal of amebic and bacillary dysentery of all types, do not know this disease. The present consensus is best expressed by Sullivan,[3] who believes that the disease develops only in individuals of definite personality types, who have had some additional psychogenic disturbance.

SYMPTOMS

The symptoms of the disease vary from a low grade inflammatory process, limited to the rectum or rectosigmoid with occasional passage of blood with bowel movements, to that of an acute case with extreme toxicity, having 15 to 20 movements per day, high fever, high sedimentation rates, leucocytosis, joint disturbances, loss of appetite, anemia, debility, weakness, protein deficiencies, and occasionally secondary liver disturbances. The process may begin in the recto-sigmoid, in the descending colon or elsewhere in the colon. I have seen cases begin in the rectum, spread upward and eventually engulf the entire colon. Crohn [4] and his colleagues reported a group that started in the cecum and worked distally. Some are limited to a regional area in the colon. We are now seeing cases in which the terminal ileum and first portion of the colon are involved. These are being called "ileocolitis". Whether this is the same disease is debatable.

COURSE

The disease may go on insidiously for months to complete remission and quiescence for years, or it may become severely acute and necessitate active hospital care for months or years. I have seen two cases in which there was no history of diarrhea. Severe hemorrhages do occur, though generally the bleeding is of low grade. The bowel may penetrate, producing localized abscesses. Cicatrization may produce obstruction. Polyposis is common. Degeneration of these with resultant malignancy is being described more and more frequently.

DIAGNOSIS

Careful history in these cases reveals mucoid or muco-purulent, bloody diarrhea, cramps, fever, malaise, loss of weight, anemia, joint disturbances, loss of appetite, thirst, and at times severe toxemia.

Crohn [5] feels that one can make a diagnosis with the bare finger examination of the rectum by palpating and recognizing the granulations of the surface of the rectum.

The disease, when present in the distal colon, can best be substantiated by endoscopy. Proctosigmoidoscopy reveals a swollen, indurated, often fiery red, mucous membrane with myriads of pin-point ulcerations, often covered over

* Read before the Section on Gastro-Enterology and Proctology, Annual Meeting of The Medical Society of New Jersey, April 27, 1948.

1. Felsen, J.: Ann. Int. Med. 10:645 (Nov. 1936).
2. Bargen, J. A.: *Management of Colitis.* National Medical Book Company, New York (1935).
3. Sullivan, A. J. and McKell, T. E.: Gastroenterology, 9:524 (1947).
4. Crohn, B. B., Garlock, J. H. and Yarnis, H.: Journal of the American Medical Association, 134:334 (May 1947).
5. Crohn, B. B.: Personal communication to the author.

by a muco-purulent, diphtheritic-like membrane. When this is wiped off, the pitted, bleeding surface remains. The more acute the disease, the more reddening, edema, and swelling are evident. The chronic case reveals more submucosal induration with cicatricial replacement of the membrane and secondary polypoid hyperplasia. Polyposis, which may occur early, is an attempt on the part of the mucous membrane to regenerate. No normal mucosa is visualized in this disease in contradistinction to the amebic or tuberculous colitis.

Roentgenograms are helpful, and indeed in cases where the disease is limited to the ascending, transverse, or upper descending colon, x-rays are a necessity for diagnosis. The roentgenogram in acute colitis reveals a "feathering" or mottling of the surface with irritability and swelling, but little narrowing of the lumen. The regional type of colitis shows the ulcerative process apparently limited to a distinct area or areas. In "ileocolitis", there are changes in the lumen of the terminal ileum and the cecum. The more frequently encountered variety is that involving the distal colon. In all of these cases, there is a lack of haustral markings, a narrowing or "lead-pipe" appearance or rigidity of the affected gut, mucosal deformity and/or destruction. Contrast barium enemas show the mucosal surface best and are essential to demonstrate polypoid degeneration and pseudo-polypoidal changes of the mucosa.

PATHOLOGY

Removed either surgically or at postmortem, the colon shows mucosal defects, shortening of the colon, submucosal induration, lack of normal mucous membrane and polypoid hyperplasia.

TREATMENT

Colitis due to dysenteric organisms or amebic infestation should be specifically treated. If the virus of lympho-granuloma is the offending organism, the patient is treated for this infection. Many cases, though not originally allergic in nature, seem to become so after months of illness. Here the allergy should be considered in the diet and care of the patient. Tuberculous enteritis demands its own specific routines. There remains, however, a large group of ulcerative colitis in which careful and prolonged search has failed to reveal an etiology. This group we are now associating with distinct personality patterns and psychogenic disturbances.

Remissions in this disease are frequent and great, even in untreated cases. At moments, when the clinician is almost despairing of the outcome, the patient often begins to improve. One of my patients, after eight weeks in the hospital, without evident improvement, was permitted to go home. The psychologic effect was excellent. He had a remission three weeks thereafter.

The earlier treatments with dilute silver and potassium permanganate irrigations are a matter of record. These were followed by neutral acroflavin irrigations, vaccino-therapy, bacteriophage instilled into the bowel and injected intramuscularly, Bargen's Vaccine, specific anti-sera, irradiated ergosterol instillations into the colon, ultraviolet ray exposure, sulfanilamide, neoprontosil, sulfaguanidine, sulfasuxidine, sulfathalidine, and, more recently, penicillin and streptomycin. Bargen[6] still believes that cases due to streptococcal infections improve with the sulfonamides and large doses of penicillin. Crohn and his associates[7] believe that streptomycin has a place in therapy. Some do improve with the sulfonamides, particularly with sulfadiazine, sulfasuxidine, sulfathalidine and more recently, other compounds of the sulfa drug now being discussed in the literature.

The nitrogen excretion or protein loss by the copious and continuous bowel movements may rise to enormous levels in 24 hours. For this reason, diet must be high in easily assimilated proteins to make up the loss and keep the patient in nitrogen balance. This can best be accomplished by using the more easily digested and absorbed, simple proteins with additional gelatin, milk proteins, albumins, occasionally supplemented by the various forms of amino acids. As the appetite is often lacking, food should always be attractively presented. The diet should be adequate, though non-residue. These patients do not readily absorb food even

6. Bargen, J. A.: Postgraduate Medicine, 2:167 (Sept. 1947).

7. Crohn, B. B., Garlock, J. H. and Yarnis, H.: Journal of the American Medical Association, 134:334 (May 1947).

from the small bowel, hence frequent feedings are often essential. The diet should include adequate carbohydrate intake for its immediate nutritional value and sufficient fluids to replace those lost by the excessive discharge. The necessary minerals and vitamins, particularly B and C, are essential to improvement. Reducing the number of bowel movements by means of bismuth and kaolin in large doses is helpful. At times, opiates may become temporarily necessary, but these should be avoided when possible. Belladonna reduces the hypermotility and cramp. It is helpful in the occaional case. At the Lahey Clinic typhoid vaccine therapy has been used with excellent results.[8] Psychotherapy in the hands of the attending gastroenterologist or, even better, under the direction of a psychiatrist well acquainted with gastrointestinal diseases, often leads to great improvement. What aids the patient in January may not help him in June. Frequent small blood transfusions of fresh, whole blood or plasma seem often to give these patients a new lease on life and should be repeated whenever blood studies show evidence of depletion. Machella and Miller [9] have treated cases by medical ileostomy or continuous drainage of the ileum with a Miller-Abbott tube associated with large, concentrated feedings of amino acids by mouth.

We can expect remissions, but never cure, by medical means. Absolute cure is obtained only by total colectomy. Spontaneous remissions vary from months to as long as twenty years, but they may be followed by serious recurrences. In a high proportion [10] of cases, medical means will not control the disease at all, and in these, some form of surgical intervention should be tried. Indications for surgery are:

(1) Unsatisfactory medical improvement.

(2) Chronic invalidism.

(3) Obstruction, perforation, or massive hemorrhage.

(4) Severe ano-rectal complications.

(5) Polypoid or carcinomatous degeneration.

Lahey [11] believes that ileostomy in early cases (before serious mucosal changes have occurred) may bring about sufficient recovery so that in the course of some years, the colon may actually be re-connected. On the other hand, every clinic has cases in which ileostomy has certainly not arrested the inflammatory processes in the colon—a fact which is evidenced by continued discharge of blood, pus or mucus from the rectum.

If, by reason of the criteria listed above, surgery is considered advisable, it is far better to undertake ileostomy at once than to permit the patient to become depleted. Ileostomy under duress has a mortality rate of 26 per cent.

This has been reduced to 4 per cent in selected cases. The acutely toxic patient is still a poor surgical risk. The mortality of total colectomy has become negligible in the last few years. Since the advent of the Kernig-Rutzen bag, ileostomy has become a less terrifying and disturbing problem.

Polyposis often begets malignancy. It continues to occur even in the disconnected colon in 4 to 7 per cent of the cases. Hence, the colon should be continuously watched by repeated sigmoidoscopy and barium enema studies.

CONCLUSIONS

Prompt and early recognition of this disease with adequate medical regime, consisting of diet, psychogenic control, chemo-and vaccinotherapy often produces remissions. Those not controllable by this means should have early surgical intervention.

There is no disease that more severely taxes the ingenuity of the attending gastroenterologist. Every means of keeping up the patient's morale and state of nutrition and keeping down the toxemia of the extensive ulcerative process must be utilized in the control of colitis.

8. Wilkinson, S. A. and Smith, F. H.: Gastroenterology, 6:171 (June 1946).

9. Machella, T. E. and Miller, T. G.: Gastroenterology, 10:28 (January 1948).

10. This figure is estimated at 25 to 30 per cent in a study by L. K. Ferguson and R. F. Welty reported in *Surgical Clinics of North America*, 27:1427 (December 1947).

11. Lahey, Frank H.: Proceedings of the Interstate Postgraduate Medical Assembly of North America, Chicago, Illinois, October 26 to 29, 1943.

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THE EFFECT OF NEUROSURGICAL PROCEDURES ON CERTAIN PSYCHIATRIC DISORDERS *

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This is a preliminary report in summary form of a cooperative research project in which the Department of Neurology of the College of Physicians and Surgeons, Columbia University, and the New Jersey State Hospital at Greystone Park collaborated in studying the effects of bilateral removal of areas of the human frontal lobes.

It has been known since 1825 that patients with frontal lobe damage became carefree and showed lack of concern for their environment. Moniz, reasoning that this carefree lack of concern might afford relief for patients overburdened with emotional conflicts, developed the lobotomy procedure in 1935. The technic was refined by Freeman and Watts and since then a number of otherwise "incurable" patients have been restored to society. The most frequently voiced objections to this procedure are (1) that often, due to lack of social inhibitions in the patient following operation, the treatment is almost as bad as the illness and (2) since so many pathways are cut, it is difficult to explain physiologically the changes that occur in the patients.

Theories of frontal lobe function have been formulated on the basis of extensive studies of patients with existing organic pathology in the frontal lobes. These data can hardly be considered relevant, however, since in all these cases, parts of the brain other than the frontal lobe were involved, either by pressure or distortion secondary to the actual lesion.

The present research was planned and executed as a peace-time application of the principle of cooperative research which was developed so successfully during the last war. It grew out of a course given by Dr. Fred Mettler to the members of the New Jersey Neuropsychiatric Association in the fall of 1946, and from his preliminary studies of the connections and function of the primate frontal cortex done during 1942 to 1944 at Columbia University with Dr. J. Lawrence Pool and Dr. Robert G. Heath. Following the lectures, opportunity was given to see whether enough suitable patients would be available to continue the study. A sizeable number of requests appeared for consideration and naturally enough these requests came from New Jersey in the area taken care of by the New Jersey State Hospital at Greystone Park. After several preliminary conferences the project was finally approved, and it was decided that a minimum of 24 operations would be needed to cover adequately the part of the brain under investigation.

As commonly performed up to 1947, the technic of frontal lobotomy was an empirical procedure. It is obvious that a systematic study of the effect of frontal lobotomy was long overdue.

The usual lobotomy is carried out through a plane which ventrally lies just rostral to the temporal pole and dorsally cuts the junction of Brodman's area 8 and 6. If such a cut disconnected all cortex rostral to it, areas 10 and 46 would be disconnected, with most of areas 9, 11, 47, 32 and a slight amount of 8 and 45. The usual incision spares most of the basal radiations and thus 11, 47 and perhaps 32. Even in cases in which the operation is done at a particular plane the amount of cortex disconnected varies and even if the same areas were always disconnected it would still be necessary to determine the critical parts of the disconnected cortex.

Could we find, for example, that only one cortical area need be removed to achieve a particular result, an essentially untidy operation could be reduced to proper surgical technic and its unnecessary damage eliminated. It is possible careful study might even reveal the mechanism by which improvement is brought about.

It was the intention to get in addition to the critical psychiatric data, as much information as possible upon any reported or suspected function of the frontal lobe. It was also necessary to have a complete estimate of the medical condition of the patient and certain precautionary data which might reveal preexisting intracranial pathology or anomalies. It was one of our purposes to see what could be done with the problem of that type of institutionalized patient who might be expected

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to spend the rest of his life in a public institution.

Patients in the project were selected from the large group of chronic cases, who remained in the hospital unimproved, after shock therapy and conventional treatment had been administered. Those with marked tension and considerable affect were interviewed. Seventy permits for operation were secured and the group was finally narrowed down to 48, with half the number to be used as controls.

It was our original desire to work with as nearly the same kind of patient as possible and while the population at Greystone (5800) is so extensive that there seemed to be no reason for going outside the hospital, anyone who imagines it is possible to obtain fifty identical cases even in this number would be excessively naive. The degree of divergence we ultimately found was surprising. Once the members of the selected group were brought together at the same time and in the same place and examined under identical conditions, very surprising differences emerged which would not have been apparent under other circumstances. We finally decided, however, that variation was desirable for it enabled us to fit the operation to the needs of the case and this was the final determining factor (medical condition being the primary factor) in selecting the cases for operation.

A thorough preliminary study was made over a period of two months. Preoperative data collected included Wassermann recheck, medical examination, complete psychiatric review, neurologic examination by three independent examiners, and x-ray films of the frontal sinuses and skull. All patients were typed for blood group. Special laboratory tests included three red, white, differential and reticulocyte counts, three hemoglobin, blood sugar, urea-creatinine, calcium, sodium and potassium analyses, a glucose tolerance test and gastric analysis. Special clinical tests included adrenalin tolerance, color vision, visual field determination, audiogram and examination of the vestibular system, x-ray determination of gastro-intestinal motility, voice recording, moving picture study and electroencephalography. Psychologic study included Rorschach for personality evaluation, Porteus maze, Wechsler-Bellevue (for intelligence quotient) and many other tests.

Twenty-four patients were subjected to operation; twenty-four others (who had exactly the same work-up) were taken to the operating room, anesthetized and contributed 500 cubic centimeters of blood. These patients constituted the controls.

The exact areas to be removed were decided in accordance with x-ray and physical findings, and the mental picture presented. The control and the operated patient matched as closely as possible considering all factors, psychologic as well as diagnostic, age, physical status, etc.

Bilateral bone flaps were turned in the temporal region, the areas exposed and identified, and the area to be removed outlined with black silk thread. Photographs were taken of the exposed brain before and after operation, and estimate of the amount removed checked against the weight of the tissue excised. The removed material was preserved with solid carbon-dioxide for study.

Each operation took about five hours. They were performed during May and June 1947, all by the same surgeon. Intravenous sodium pentothal was the anesthetic. Many patients were conscious at the close of the operation and could answer questions and help move themselves from the operating table.

All patients were re-examined and re-tested three weeks and again four months after operation. All have been reviewed seven months and again one year after the operative period.

Our group of patients, because of the chronicity of their illness and preponderance of schizophrenics had a poor prognosis with any type of treatment. All of the patients felt they had received a special treatment since patients from the unoperated group were anesthetized during the operative period and blood was taken from them to be used for transfusion. Three of the 24 control patients are now out of the institution, one appears to be making an excellent social adjustment one remains hypo-manic but capable of adjusting socially and the third resides in a camp doing odd jobs but is incapable of finding gainful employment.

In the operated group, 11 of 24 patients have gone home and to work. Ten are gainfully employed. The eleventh patient has returned to housekeeping. Of the 13 remaining

operated cases, several have improved to a lesser degree.

Nine of the 11 cases now working had area 9 or area 10, or both, removed, the most frequent additional zone being the relatively small area 46 which adjoins 9 and is similar in cytoarchitecture. One of the 11 cases had area 46 alone removed but cytologic study showed that small amounts of 9 and 10 were also included. Although schizophrenic, his preoperative social adaptation was marginal and operation produced definite but not as startling effects as that following the removal of areas 9 and 10. The remaining patient, a manic depressive with many past remissions had area 11 removed bilaterally. Although sufficiently improved to be paroled, she has continued mildly elated.

When clinically observable change resulted from operation it was essentially of the same nature *regardless of parts of the frontal cortex removed.* No patients were made worse and most areas produced very slight or no improvement. The idea of specific localization for different personality patterns in the frontal lobes can be discarded. Changes were constantly in the sphere of affective response. Emotion was not absent nor even noticeably blunted. Rage, fear and joy were still felt; the change being that they did not affect the patient so profoundly. Emotions were readily and more appropriately discharged. Repression and unpleasant emotions with resultant tension and subsequent regression into overt psychotic behavior no longer occurred. When questioned as to the effect of the operations almost all patients gave similar answers: "The tensions don't pile up," "I'm not full of fear like I used to be," "I don't feel like I'm carrying a tremendous load any longer," etc.

Area 6 was removed alone in two patients, area 8 in one. Area 45 removed alone produced no change. One patient had area 44 alone (Broca's area) removed and her word-salad, delusions and hallucinations were unaffected.

Ten of the eleven patients now working had parts or all of areas 9 and/or 10 removed alone or in combination with other areas. This suggests that a specific desirable effect follows removal of this region. There are, however, five patients who, despite ablation of these areas, remain institutionalized. In contrast to the minimal change or no change that followed removal of other areas, these patients obtained the desired effect and remain hospitalized despite this. In three cases, overt symptoms of the psychosis disappeared but because of impulsiveness, tactlessness and irresponsibility, they remained hospitalized. All are on less disturbed wards. These patients all had a large amount of cortex removed in addition to area 9 and/or 10 and we feel that this accounts for the appearance of the deleterious symptoms. The fourth case (in this group of five) was in an elated state when operated upon. The fifth improved considerably and was paroled and we feel that her return to the institution was caused by lack of proper support in the home.

In view of most previous claims about the great importance of the frontal lobes to the mental life of the individual, it is remarkable that so few changes were found. Thirty-five different tests were given before operation, repeated three weeks after operation and again four months after operation. Some 135 different scores of performance were derived. Nine times out of ten, neither the average nor the variability of the operative group differed significantly from that of the control group. The Wechsler-Bellevue test was unchanged. The sorting test and tests of ability to generalize or to abstract were not significantly changed. All learning scores and most memory scores were unaltered. Most of the Rorschach scores were unchanged. The tests which showed real changes which might be attributed to the operation are both few and puzzling. The outstanding alteration brought about was the decrease in self-referred and self-conscious anxiety and the mental and physical complaints. This last seemed to be a highly specific alteration and one which was closely allied to social recovery. This loss in anxiety and in physical and mental complaints may explain the changes obtained in other tests. Excision of areas 9, 10 and 46 in psychotic patients was followed by a loss of self-conscious anxiety. This loss is not shown in any uniform fashion by patients who did not have these areas excised. In most patients, the changes in psychologic

test performance and efficiency can be understood in terms of increased efficiency due to loss of emotional tension.

In September, eight patients underwent lobotomy in accordance with the Freeman-Watts technic. Two patients who originally had topectomy without improvement were included. They also failed to improve after lobotomy. Of the remaining six, there was disappearance of overt psychotic symptoms in three, although only one, five months after operation, was able to work for a living. His job was considerably below his former capacity. Of the three who improved, two were catatonics and one was a paranoid schizophrenic with persecutory delusions to which he reacted with considerable affect. Similar patients in the topectomy group who had 9 and/or 10 operations also improved and are working.

Although three of these cases are now devoid of overt psychotic symptoms (by virtue of the same alteration of affective response described for topectomy) they are, nevertheless, considerably different from the successful topectomy cases. They all show the tactless, carefree, irresponsible behavior with lack of initiative and absence of remorse that was characteristic of the topectomy cases who had too large an area of cortex removed. This was expected since in these cases a very large proportion of the frontal lobe was undercut.

It becomes apparent that these changes in behavior are essentially the same when cortex is removed as when it is undercut. In both procedures, the corticifugal and corticipetal fibers are interrupted. In the cortical operation, long and short cortical association fibers are interrupted. This does not happen in lobotomy. The corticifugal and corticipetal fiber tracts are, therefore, much more important in determining the behavior than the cortical association fibers.

From this survey one is able to judge where topectomy should fit into the psychiatrist's armamentarium. Its specific effect is to alter the affective response so that tensions do not accumulate, thereby making regressive reparative behavior unnecessary. A thorough psychiatric evaluation, keeping this point foremost, is the only method of selecting cases for operation. Haphazard recommendations will simply increase the ratio of failures and will even take in patients who could have been helped by more conservative measures.

The conventional diagnostic categories cannot be the only criteria in determining whether a patient is a suitable candidate for operation. Cases of agitated depression and involutional paranoid states because of the intense affective component to their illness (and its appropriateness to ideation) have a very favorable prognosis.

SUMMARY

(1) Beneficial effects resulting from frontal lobe surgery are due to alteration of the affective responses.

(2) This effect appears only if areas 9 and/or 10 are encroached upon at operation.

(3) A large proportion of patients in whom more than two large areas (or several small cortical areas) are removed will show signs of deterioration in social behavior.

(4) Patients whose overt psychotic symptoms are removed by operation showed essentially the same basic personality traits that were present before the illness began.

(5) In chronic psychotics, affect becomes divorced from ideation especially in schizophrenics and manics. As this dissociation increases, prognosis with operation becomes less favorable.

CONCLUSIONS

The topectomy operation is a therapeutic procedure in the same way that removal of the thyroid gland is therapeutic for goiter. In each instance there are results in the release from emotional tension and, if successful, a better life adjustment. Removal of areas 9, 10 and 46 of the frontal lobes permits the restabilization and orderly balance of psychologic functions in mental patients having great self-referred anxiety together with many mental and physical complaints.

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MYELOGRAPHIC STUDIES WITH PANTOPAQUE*

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Examination of the subarachnoid space of the spine has undergone numerous stages in the past. In earlier examinations of the lower spine, air and oxygen were used as contrast substances. This proved satisfactory in the hands of some radiologists for determining the presence or absence of the larger, more obvious lesions. Lipiodol, which was first used in 1922 by Sicard and Forestier, overcame some of the objections and shortcomings of the less contrasty media. There are, however, numerous objections to the use of lipiodol. Because of its high viscosity it is injected with some difficulty and it does not permit of withdrawal following the examination. It globulates easily and this makes it unsatisfactory for the detection of many cases of minimal encroachment on the subarachnoid space. Lipiodol is also non-absorbable. Pantopaque, introduced in 1941, overcame many of the objections which previous contrast substances had encountered. Pantopaque is a highly contrasty iodine preparation with a low viscosity. It flows readily through an 18 or 20 gauge needle and can be injected easily into the subarachnoid space. When introduced properly it remains in a rather homogeneous mass, flowing easily up and down the spine with the patient in different positions. It is relatively non-toxic and, in the hands of an experienced team, can be removed quite readily. It is absorbed at a rate of about one cubic centimeter per year.

TECHNIC

After thorough surgical preparation with complete asepsis, the patient is placed prone on the fluoroscopic table with the feet against the end board. A pillow is placed beneath the abdomen to straighten the lower spine. The head is elevated to a slight degree. In this position, an 18 or 20 gauge needle is introduced at the third, fourth or fifth lumbar interspace. An effort is made to place the needle one space above or below the suspected area involved because of false defects caused by the pressure of the needle. Remove a small amount of spinal fluid to determine the cytology and chemistry. Approximately three cubic centimeters of pantopaque are introduced with a small syringe. This amount can be increased to five or six cubic centimeters, but it is not usually necessary to do so in the lumbar region. In the cervical and dorsal areas, six cubic centimeters are required because of the width of the canal at these levels. Some use nine cubic centimeters in the cervical portion of the spine.

After the contrast medium has been injected the syringe is removed and the stilet replaced in the needle which is covered with a sterile dressing.

An examination is now begun by the fluoroscopist after thorough accommodation in a dark room. Too much stress cannot be placed upon the importance of taking sufficient time to accommodate one's eyes for this portion of the examination. Under fluoroscopic control, the contrast substance is allowed to flow distally through the lower portion of the lumbar spine and, (with the feet tilted downward), the caudal sac is filled. At each intervertebral space the column of pantopaque is observed in the direct antero-posterior projection, as well as both oblique positions. When there is any suspicion of a defect anteriorly the patient can be turned into almost a lateral position. Spot films are taken of the lower lumbar region when any questionable defect is seen fluoroscopically. Following investigation of the lower lumbar region, the upper lumbar spine can be examined in the usual Trendelenberg position. Examination is usually limited to the lumbar and lower dorsal portions of the spine. The patient is then returned to the horizontal position and routine films are taken of the third, fourth and fifth lumbar intervertebral spaces with the tube over the table. These films are taken in the postero-anterior and both oblique positions. A true lateral is done by leaving the patient in the prone position and turning the x-ray tube to the side of the table. Following this procedure the pantopaque is returned, under fluoroscopic control, to the region of the tip of the needle.

Aspiration of the oil can now be attempted. If the oil is properly pooled at the tip of the needle at least ninety per cent of the contrast medium should be aspirated. Impingement of the needle against a nerve root or the side of the canal sometimes causes difficulty in withdrawing the oil. A slight rotation of the needle will overcome this difficulty. Increasing the intraspinous pressure by coughing or the usual Valsalva technic will sometimes force the oil out through the needle. There is no objection to leaving some of the oil in place if too much difficulty is encountered in its removal. After having removed as much oil as possible, with the usual care the needle is withdrawn and the patient is kept for approximately twenty-four hours in the horizontal position.

DEFECTS IN THE COLUMN OF PANTOPAQUE

Lesions intruding upon the subarachnoid space of the spine manifest themselves by defects in the column of pantopaque which range

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from the minimal encroachment with a small lateral defect or distortion (or obliteration of a root sleeve) to the more obvious large defects causing a unilateral or bilateral filling defect in the side of the column of pantopaque. The maximum defect obviously is the complete blocking of the canal. Any defect in the column of pantopaque should be investigated, allowing the pantopaque to flow forward and backward several times to rule out a false defect due to failure of the contrast media to fill the area adequately. A constant finding of an obliterated or elevated root sleeve may be the only indication of a partial herniated intervertebral disc. Symmetrical constriction of the column of pantopaque at the level of an intervertebral space may be due to a bilateral herniation of the disc. Thinning of the column of pantopaque without an obvious lateral defect is frequently a sign of a central protrusion of the disc. This can be demonstrated in the lateral or oblique projection. It is frequently overlooked if the patient is not examined in all positions. The larger defects causing incomplete or complete obstruction must be investigated very carefully. The appearance of the incomplete defect may be more readily appreciated if the patient is examined in the vertical or complete Trendelenberg position. In this position a small amount of the contrast substance may be seen trickling around a large fragment of the intervertebral disc. In complete obstructions it sometimes is an advantage to introduce the contrast substance above and below the level of obstruction. Defects at more than one level are occasionally seen and one must stress the importance of examining the intervertebral space at all levels of any portion of the spine under investigation.

Some difficulty may be encountered in reaching the subarachnoid space. Occasionally the oil is introduced outside the arachnoid resulting in a rather typical pattern in parallel columns on either side of the canal, together with lateral projection of the oil around the lumbar and sacral nerves. This oil cannot be withdrawn if it has been introduced outside the arachnoid. One must await normal absorption.

ERRORS IN INTERPRETATION

Errors in interpretation are frequently caused by anatomic variations with a narrow canal. Likewise, adhesions from a previous arachnoiditis or previous surgery may be the cause of wrong interpretation and diagnosis. Varices within the subarachnoid space may also cause a rather bizarre pattern which must be distinguished from a true filling defect of a mass. Osteophites protruding from the margins of the vertebral bodies and encroaching upon the subarachnoid space may also lead to errors in diagnosis. Sometimes a high termination of the caudal sac will suggest a block from a tumor or other lesion. The variation of the position of the caudal sac in the normal must be kept in mind to obviate this error. The caudal sac has the usual termination in a concave appearance.

COMMENT

Examination of the subarachnoid space with contrast media should be preceded by a complete history and neurologic examination. Plain films of the portion of the spine involved should precede myelographic examination. These examinations, if carried out thoroughly, will frequently point to the area involved and limit the duration and extent of the myelographic procedure. Narrowing of an intervertebral space is frequently a definite indication of changes in the intervertebral cartilage Unilateral widening of an intervertebral space suggests possible impingement on a peripheral nerve. Pantopaque myelography should precede surgical exploration of the spine for tumor or herniated intervertebral disc because it gives an accurate picture of the level involved. It will determine the presence of multiple herniations of the discs, minimize errors in diagnosis, and frequently protect the patient from unnecessary laminectomy. Because of the low toxicity and non-irritating effect of pantopaque, and also because it is easily absorbed with practically no residual effects if allowed to remain in the spinal canal, there is little objection to the use of this contrast substance for diagnostic purposes.

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EARLY DIAGNOSIS OF DIABETES MELLITUS *

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Typical cases of diabetes mellitus seldom present diagnostic difficulties. The mild and unsuspected cases, however, are diagnostic problems. Recent surveys [1] of the general population indicate that these mild and unidentified cases are more numerous than was suspected. We must diagnose these cases early.

Delay in diagnosis is usually due to ignorance of the nature of the disease on the part of the laity, hesitancy to consult a physician early because of economic reasons or reluctance to submit to the contemplated disciplinary regimen. Delay in the diagnosis of the mild or unsuspected cases may also be attributed to the physician.

EARLY DIAGNOSIS

An early diagnosis of diabetes is important so that adequate treatment can be given promptly, perhaps during the period before pathologic changes in the islet cells of the pancreas are irreversible.[2] Early diagnosis with adequate treatment results in better control favoring a milder routine,[3] in reducing the liability to serious progression thus retarding the development of dangerous complications, especially an attack of ketoacidosis or coma, and in saving in mortality. Early diagnosis of borderline cases, (the so-called potential or prediabetics) may be helpful in preventing these individuals from developing true or at least severe diabetes.[4]

Finding sugar in the urine (a positive reduction test determined by a standard Benedict's qualitative test for urine sugar) or a history of the finding of sugar in the urine at any time, leads to the diagnosis of diabetes.

Chances of early discovery of diabetes are thus enhanced by frequent routine urinalysis for sugar, not fasting but especially after meals rich in carbohydrate. All patients and even well persons should have their urine examined periodically. Glycosuria implying diabetes may be found at any period from infancy to old age. The glycosuria may be persistent or intermittent and may vary from mere traces to large amounts.

Diabetes should never be excluded on the strength of a single negative urine-sugar test. Especially should the practitioner re-examine the urine of overweight adults, of married women over forty years of age, of the offspring and collateral relatives of diabetic persons.[5] The doctor should not wait for the development of, nor depend on typical symptoms to start the early diagnosis. Many cases of diabetes begin insidiously and present no symptoms in the early stages of the disease.[4] Even persons with diabetes of long duration, where the onset of the disease has been a gradual one, may be free of symptoms.[6] Many persons with diabetes are unaware of the significance of these symptoms and do not seek early medical advice.

GLYCOSURIA

Not all sugars found in the urine with ordinary testing reagents are indicative of diabetes. It is unwise to indulge in guess work in the interpretation of reduction tests, or to make a positive diagnosis of diabetes in all cases showing sugar in the urine, or to dismiss a transitory slightly positive reduction test as being of no consequence.[7] All positive reduction tests should immediately be investigated and identified, to determine whether the individual has true diabetes or a nondiabetic glycosuria (or melituria). Bear in mind, however, that persons with nondiabetic glycosuria initially are not exempt from the average inci-

* Read before the Section on Diseases of Metabolism at the 182nd Annual Meeting of The Medical Society of New Jersey, Atlantic City, N. J., April 29, 1948.

1. Beardwood, J. T.: American Journal of Digestive Diseases, 11:345, (Nov. 1944). Also see: Wilkerson, H. L. and Kroll, H. P.: Journal of the American Medical Association, 135:209, (Sept. 27, 1947).
2. Copp, E. F. and Barclay, A. J.: Journal of Metabolic Research, 4:445, (Sept. 1923); also, Haist, R. E. and Best, C. H.: Proceedings of the American Diabetes Association, 1:31, (1941); and also, Lukens, F. D. and Dohan, F. C.: Endocrinology, 30:175, (Feb. 1942).
3. John, H. J.: Proceedings of the American Diabetes Association, 3:71, (1943).
4. Blotner, H.: Journal of the American Medical Association, 131:1109, (Aug. 3, 1946).
5. Joslin, E. P., et al.: *Treatment of Diabetes Mellitus.* ed. 8. Lea & Febiger, Philadelphia, (1946).
6. John, H. J.: *Diabetes.* ed. 1. Mosby Company, St. Louis, (1946).
7. Wolman, I. J.: American Journal of the Medical Sciences, 212:159, (August 1946).

dence (9.9 per cent) of eventually developing true diabetes.[8]

In general, if a person has sugar in the urine, it is a safe rule to consider this as a sign of diabetes until the reduction test is proved by reliable chemical studies to be not diabetic in etiology. This should be done immediately. No positive diagnosis of diabetes should ever be made without confirmatory blood sugar evidence.

HYPERGLYCEMIA

Hyperglycemia in addition to glycosuria is essential for the diagnosis of diabetes. It may be observed in fasting or after carbohydrate ingestion. The diagnosis of mild diabetes depends on the recognition of the early deviation of the blood sugar levels from the normal.

The concentration of the normal fasting blood sugar is maintained rather constantly between 80 to 120 milligrams per hundred cubic centimeters. Venous blood is tested by the method of Folin and Wu. In normal young individuals within forty-five to sixty minutes following an average carbohydrate meal the content of sugar in the venous blood rises but rarely goes beyond 140 to 160.† This initial rise is followed by a steady fall in the blood sugar level and within two hours the blood sugar falls to its original fasting level or even below. No sugar appears in the urine at any time.

Increase of the sugar content of the venous blood above these levels is considered as hyperglycemia: fasting blood sugar values over 120,† blood sugar values one hour after a carbohydrate meal over 160,† or blood sugar values two to two and one-half hours after a carbohydrate meal over 120.†

In mild or latent cases, the hyperglycemia may fluctuate from day to day. Therefore, the higher the blood sugar value above normal levels at the time of observation, the more certainty there is of the existence of diabetes.

BLOOD SUGAR TESTS

In attempting to make a final positive diagnosis of diabetes the following procedure should be adopted.

Finding a reducing substance in the urine should be followed by a determination of the sugar content of a venous blood specimen, taken after an overnight fast (fasting specimen) and/or after a full carbohydrate meal (postprandial specimen), and a simultaneous qualitative analysis of a urine specimen for sugar.

If a person has glycosuria and the fasting blood sugar value is 130† or higher, the diagnosis of diabetes may be warranted, provided no other cause for hyperglycemia is apparent.

Glycosuria with fasting hyperglycemia, although strongly suggestive of diabetes, occurs in other conditions. Patients with hyperthyroidism, hyperpituitarism, or tumors of the adrenal glands frequently exhibit a fasting hyperglycemia, though it is seldom pronounced. In older people with chronic nephropathies and in chronic arterial hypertension[9] definite hyperglycemia and glycosuria is sometimes encountered. In patients exhibiting any of these conditions, a definite diagnosis of diabetes can, at times, be made only with a glucose tolerance test.

The fasting blood sugar value alone is in itself not always diagnostic. Mild or latent cases frequently have fasting blood sugar values within normal limits and even sugar-free urines.[4] Some clinicians prefer to determine the blood sugar concentration after a full carbohydrate meal in order to establish the diagnosis.

The criteria for the diagnosis of diabetes according to the postprandial blood sugar values, vary with different authorities. Joslin[5] states that glycosuria and a blood sugar value, taken one hour after a full carbohydrate meal, of 170† or more, is indicative of diabetes. Duncan[10] maintains that glycosuria plus a two hour postprandial blood sugar value in excess of 160† makes the diagnosis of diabetes certain. John[6] assumes that a two and one-half hour postprandial blood sugar value of 120† or less, is an important criterion and can be considered as normal.

Tests of blood and urine sugar taken one hour after a full carbohydrate meal[1] have been

† Milligrams per 100 cubic centimeters of blood.

8. Marble, A., et al.: American Journal of the Medical Sciences, 197:533, (Dec. 1939). Also see: Dewees, E. J. and Langer, P. H.: Transactions of the Association of American Life Insurance Medical Directors. 29:105, (1943).

9. Grafe, E.: *Metabolic Diseases.* Lea & Febiger, Philadelphia, (1933).

10. Duncan, G. G.: *Diseases of Metabolism.* Saunders, Philadelphia, (1942).

found to constitute a more reliable and useful index for the diagnosis of diabetes.[4]

The diagnosis of diabetes in the presence of hyperthyroidism is made if, the fasting blood sugar is 150† or more; or one hour after a meal is 200† or more in addition to glycosuria.[5]

In evaluating blood sugar tests do not depend solely on the initial value for the final diagnosis of diabetes unless it is significantly above normal concentration. There is always a possibility of laboratory errors, and many other nondiabetic factors may temporarily interfere with carbohydrate metabolism and produce hyperglycemia. A final diagnosis of diabetes based on a single blood sugar analysis showing a slightly elevated hyperglycemic value must have concomitant glycosuria which is plainly related to diet, and characteristic symptoms of diabetes.[10] In doubtful or borderline instances, a positive family history of diabetes is suggestive of the existence of the disease.[11]

In all cases, repeat the initial examination of the blood and urine for sugar. Unless the subsequent determination of the blood sugar level shows a definite hyperglycemia and glycosuria, the positive diagnosis of diabetes should be deferred until a standard (one-dose) oral glucose tolerance test is performed. A normal second blood sugar test following an initial borderline test † may be considered to be nondiabetic.

I mention the standard (one-dose) oral glucose tolerance test, because in routine clinical practice I have found this more dependable for diagnosis than the "Exton-Rose" test, even though the latter saves laboratory time.

GLUCOSE TOLERANCE TEST

Fasting or postprandial blood sugars significantly above normal concentration, and especially when clinical symptoms of diabetes are present, do *not* warrant a glucose tolerance test.

When the postprandial blood sugar values are repeatedly borderline and there is doubt about the diagnosis of diabetes, or on the other hand, if the blood sugar determinations are within normal limits and glycosuria is present, the standard oral glucose tolerance test should be performed. For the diagnosis of the mild or latent cases of diabetes this test is of value and may be the sole criterion.[12]

The standard oral glucose tolerance test is an examination of the response of the blood sugar concentration and urine to the oral administration of glucose. The blood sugar curve after loading with glucose is the most sensitive indicator of the ability of the body to utilize carbohydrate. Consideration must be given, however, to certain factors that may have an effect on carbohydrate tolerance and produce "pseudodiabetic curves".

Important influencing factors are the following: character of antecedent diet,[13] infection,[5] previous physical activity, emotional disturbance and menstruation. Other pathologic and physiologic states, such as other endocrine disease (hyperthyroidism, hyperpituitarism, adrenal medulla tumors),[14] liver disease,[15] obesity,[16] old age,[17] and gastrointestinal disorders,[5] must be given due weight in interpreting results.

Some of these predisposing influences can be corrected so that the test may be performed under the most favorable conditions. The individual under observation should be placed on a well balanced diet containing a daily intake of at least 300 Grams of carbohydrate, 80 Grams of protein, and calories sufficient for maintenance for at least three to five days prior to the performance of the test.[18] No insulin should have been taken during this time. Make certain that no infection or fever exists. Unusual physical exercise and emotional disturbance should be eliminated as much as possible before, or during the test. Smoking should be avoided on the morning of and during the test. Tests should not be carried out near the time of the menstrual period.

11. Blotner, H. and Hyde, R. W.: Journal of the American Medical Association, 122:432, (June 12, 1943); also, Stieglitz, E. J.: *Geriatric Medicine*. Saunders, Philadelphia, (1943); and also, Colwell, A. R.: *Diabetes in General Practice*. Year Book Publishers, Chicago, (1947).
12. Spellberg, M. A. and Leff, W. A.: Journal of the American Medical Association, 129:246, (Sept. 22, 1945).
13. Sweeney, J. S.: Archives of Internal Medicine, 40:818, (Dec. 1927).
14. John, H. J.: Endocrinology, 13:388, (Oct. 1929).
15. Soskin, S. and Levine R.: *Carbohydrate Metabolism*. University of Chicago Press, (1946).
16. Newburgh, L. H. and Conn, J. W.: Journal of the American Medical Association, 112:7, (Jan. 7, 1939).
17. Hale White, R. and Payne, W.: Quarterly Journal of Medicine, 19:393, (Sept. 1926).
18. Conn, J. W.: American Journal of the Medical Sciences, 199:555, (April 1940).

† Milligrams per 100 cubic centimeters of blood.

Technic—Have the patient eat his prescribed evening meal but take no food after 7 p. m. on the evening before the test is to be performed. In the morning, empty the bladder completely and obtain a sample for sugar estimation. At the same time obtain a sample of venous blood for fasting sugar concentration. Then administer 100 Grams of glucose orally if the patient is an adult. For children, the dose of glucose is one Gram per pound of body weight. The glucose is dissolved in water (2.5 cubic centimeters of water for each Gram of glucose), to which the juice of half a lemon is added for flavoring and to prevent nausea. This is preferably served cold. Make certain that the patient takes and retains the full dose of glucose prescribed. Nausea and vomiting preclude the accuracy of the test.

Collect specimens of venous blood and simultaneous urine samples for sugar determination at the end of one-half, one, two and three hours after ingestion of the glucose. The blood sugar determinations coupled with the results of the urinalyses, give an indication of the renal threshold to glucose. The renal threshold for glucose may be defined as the percentage level of sugar in the blood above which sugar appears in the urine. In health this varies, on the average from 160 to 180† for venous blood.[5]

Following the ingestion of glucose, certain features of the blood sugar curve are discernible which characterize a normal and a diabetic curve. Take into account: (1) the fasting blood sugar level; (2) the height (peak-value) of the curve and (3) the duration of the hyperglycemia.

THE NORMAL CURVE

The ingestion of a measured dose of glucose in the normal young person is followed by a slight rapid increase in the normal fasting blood sugar concentration. The maximum level of the blood sugar is usually reached within one-half to one hour and rarely exceeds 140 to 160†. This initial rise is then followed by a steady rapid fall in the blood sugar level and within two hours the blood sugar falls to its original normal fasting level or even below the intial value. Sugar is not present in any specimen of urine.

THE DIABETIC CURVE

Persons with diabetes react differently. The fasting blood sugar level is high; as a rule above 130† in all but the mild cases. Following the ingestion of glucose there is a slow progressive rise in the blood sugar concentration, the maximum level of the blood sugar requiring anywhere from one to three hours to be reached. As a matter of fact there is no maximum level of the blood sugar; it may be at 170† or higher. This rise is followed by a slow fall in the blood sugar level, a return to the initial fasting level requiring from three to five or even seven hours. Sugar is present in the urine samples depending upon the renal threshold. In mild or latent diabetes the curve may closely resemble the normal.

Definite criteria for diagnosis of the diabetic blood sugar curves vary with different authorities in the field of diabetes. Some clinicians [4] are interested primarily in the height [5] (peak-value) of the blood sugar curve, stating that a value of 170† or above, plus glycosuria, is indicative of diabetes. Others [6] are interested[10] only in the duration [19] of the hyperglycemia, while different workers [20] are interested in the combination [21] of the two characteristics. The height of the blood sugar curve depends largely on the rapidity of absorption of the glucose from the gastrointestinal tract. It has no particular significance [22] in the diagnosis.

The rate of decline of the blood sugar to the fasting level (duration of the hyperglycemic phase), represents the rate of utilization of the glucose. This is the most important part [22] of the observation, so far as making a diagnosis of diabetes is concerned. Although a high blood sugar curve may indicate interference with carbohydrate metabolism this is not necessarily indicative of diabetes [21] unless it is also prolonged.

Accordingly, using this latter feature as the significant criterion for the diagnosis of diabetes it can be inferred that an initial fasting blood sugar value of 120† or below, plus ability to achieve a normal blood sugar value within two hours following the ingestion of a measured dose of glucose, indicates normality [10] of carbohydrate metabolism and can be accepted [19] with assurance as evidence of the absence of diabetes.[23]

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19. Lawrence, R. D.: Medical Clinics of North America, 31:289, (March 1947).
20. Bodansky, M. and O.: *Biochemistry of Disease*. Macmillan, New York, (1946).
21. Mosenthal, H. O.: Medical Clinics of North America, 31:299, (March 1947).
22. Sevringhaus, E. L.: Proceedings of the American Diabetes Association, 4:121. (1944).
23. Wilder, R. M.: *Clinical Diabetes and Hyperinsulinism*. Saunders, Philadelphia, (1940).

† Milligrams per 100 cubic centimeters of blood.

Undue prolongation of the hyperglycemic phase with delay in return of the blood sugar to the fasting level for three hours or more, is evidence of the presence of diabetes provided no other obvious cause for disturbed carbohydrate metabolism is present.

Do not establish the final positive diagnosis of diabetes on the basis of a single glucose tolerance test unless it is highly abnormal.[12] The borderline between the normal and the diabetic curve may be difficult to delineate. When the results are borderline, inconclusive, or ambiguous, the test should be repeated after a week or ten days, before attempting to draw any conclusion. Further borderline results do not necessarily rule out the possibility of diabetes. If the curve is still doubtful, repeat the test in three or six months. Time alone usually settles the definite diagnosis.

SUMMARY

1. The importance of early diagnosis of diabetes mellitus with adequate early therapy is stressed.

2. The value of routine urinalyses for sugar and the unreliability of symptoms in the diagnosis of early diabetes is considered. Diabetes should never be diagnosed simply because sugar has been found in the urine. The glycosuria of diabetes must be accompanied by hyperglycemia.

3. An outline of steps to be followed in making a diagnosis of diabetes is presented. A correct diagnosis is dependent upon systematic studies of the blood sugar.

4. Criteria for the diagnosis of diabetes according to fasting or postprandial hyperglycemia are pointed out. Normal fasting blood sugars do not rule out diabetes. A postprandial one hour blood sugar is more valuable as an index for the diagnosis of diabetes than a fasting blood sugar.

5. The technic of the conventional oral glucose tolerance test and the value of correcting influencing factors are discussed.

6. Interpretations of characteristic curves that show absence or evidence of diabetes are reviewed.

50 Glenwood Avenue

DISCUSSION

Dr. William Nyiri (Newark): During the course of many years, we have experienced two shortcomings in evaluating blood sugar determinations. First, no method is entirely free of the possibility of technical errors. Perhaps new, simpler and more reliable methods will soon appear. Dr. Joslin predicted that one was soon coming out of his service. Second, the height of the fasting blood sugar frequently varies with the hour of the morning. Unless, as Dr. Fineberg points out, the same circumstances are observed, this may lead to erroneous interpretation.

There is a controversy as to whether the standard one dose glucose tolerance test or the Exton-Rose double dose test is preferable. The tests are based on different principles. The sugar curve of the first depends on the rate of sugar oxidation in the body; the second one is an expression of insulin reserve in the pancreatic gland. Personally, I combine these two principles by using the Exton-Rose technic and continuing with hourly blood sugar determinations for two to three hours. No matter how conscientious a case study may be, there will always remain a small number in which no definite conclusions can be reached.

If the result of the diagnostic procedures, as outlined by Dr. Fineberg are questionable, it is wiser to caution the patient and keep him in suspense, rather than disregard the possibility of a latent disturbance of the carbohydrate metabolism, and risk seeing the case develop into a more severe diabetes and its possible sequelae.

INSULIN IN ALCOHOLISM

Insulin may be effective in acute alcoholism even when not balanced by glucose. Vassaf and Hall treated 43 patients by gradual withdrawal of alcohol and injection of 10-unit doses of insulin three times daily before meals, without glucose. The average withdrawal period was shortened by half, and three times as many patients as usual neither required nor demanded whisky after admission. Weight gain was increased threefold over that of non-insulin treated patients. Insulin reactions were rare, mild, and readily controlled.—*New England J. Med. 235:190.*

CEREBRAL PALSY: RECENT ADVANCES IN DIAGNOSIS AND CLASSIFICATION*

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Cerebral palsy is one of the great causes of crippling in children, second only to infantile paralysis of which a great deal more is heard. In the country today there are about 176,000 children with cerebral palsy. If one also adds the number of cerebral palsied individuals through the age of forty, this figure would come to nearly 344,000. There is an annual increment of seven cerebral palsied children per 100,000 of the general population. Unlike poliomyelitis which strikes in epidemics (and for which enormous resources are now available) there is no reason to expect that cerebral palsy will soon be conquered.

We are then faced with the tremendous task of caring for these handicapped children. The practitioner can no longer offer the enlightened parent of today words of disappointment due to a lack of understanding of what can be done to rehabilitate these children. One cannot tell these parents to abandon their handicapped children. Recently, great advances have been made in the diagnosis and classification of these disorders, and in the development of treatment and training facilities. Only 25 to 30 per cent of these children are feebleminded; it is incumbent on us to train and educate the remainder in such a way that they can take their places in society.

This task can be successful only if physicians, parents, educators and other workers concerned with the cerebral palsied child completely understand this complex clinical entity. Cerebral palsy is a general term representing several conditions which are grouped together because they are all caused by injury or disease of some part of the brain. The term "spastic paralysis" designates only one type of neuromuscular disorder in the general classification of cerebral palsy. Cerebral palsy differs from other types of physical handicaps in that it represents multiple disorders, motor and sensory, in the same individual. Dr. Phelps has divided the cerebral palsy group into five distinct clinical types:

1. True cerebral spastic paralysis (20%)
2. Athetosis (40%)
3. Rigidity (20%)
4. Ataxia (10%)
5. Tremor (5%)

This classification is based on the outstanding clinical manifestations displayed by the patient. The intracranial pathology responsible for the cerebral palsy falls into three general groups:

1. Lesions of the motor cortex.
2. Lesions of the basal ganglia.
3. Lesions of the cerebellum.

Lesions of the motor cortex result in spasticity and flaccidity of muscles; lesions at the base of the brain (more specifically the basal ganglia) athetosis, tremor and sometimes rigidity; lesions of the cerebellum cause ataxia and incoordination; and diffuse lesions of the brain produce rigidity.

The lesion itself is most commonly hemorrhage with destruction of nerve cells by direct replacement with scar tissue, by pressure upon nerve cells, or by anoxemia. Often the lesion is in the nature of agenesis or a malformation of that part of the brain. Damage to the cerebral cortex produces spasticity or flaccidity or both, depending on the location of the lesion. True spasticity results from involvement of the premotor area (area 6 of the Brodman classification) of the cortex, whereas a lesion of the motor area proper (area 4) results in flaccid paralysis. Because of the proximity of these areas, the lesion usually extends to involve a part of both areas giving a clinical picture of spasticity and flaccidity of muscles. A diffuse lesion of the cerebral cortex, (usually small petechial hemorrhages) will produce a rigidity of the muscles and is often associated with retarded mental development because of involvement of the frontal lobes. In this type, too, the involvement is more likely to include all four extremities and speech. The lesion may be located toward the vertex of the brain and affect the legs chiefly; or it may extend lower down in the motor area and also affect the arms. If the lesion is on one side of the cortex, a hemiplegia of the contralateral side of the body will be present. Lesions in the midbrain involving the basal ganglia give rise to athetosis or loss of control of voluntary motion. Any impairment of this area will allow involuntary

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motions to interfere with normal willed motions. Injuries to the basal ganglia may give rise to tremor. Tremors are manifested by involuntary motions which are reciprocal in nature and regular in rhythm. Lesions of the cerebellum will result in ataxia, due to damage to or failure of development of the automatic balance control centers in the cerebellum. This results in a loss of the ability to carry out desired movements in desired directions and a characteristic loss of equilibrium in walking and standing.

It has long been considered that the chief cause of cerebral palsy was an injury to the brain at time of birth. More recent estimates made available by Ford[1] attribute 6 per cent of all cases to poor obstetric supervision. Phelps[2] has found in a larger series of cases, that this figure is less than 3 per cent. In the etiology of cerebral palsy, three classifications have been established: prenatal, natal, and postnatal. In the *prenatal* groups, congenital defective development is the most common offender, especially in the ataxia and certain of the athetoids. This causal relationship has been demonstrated at autopsy. Other less common but important prenatal factors are: (1) toxemias of pregnancy, (2) vitamin and mineral deficiencies, (3) premature separation of the placenta, (4) endocrine dysfunction. Cerebral palsy is not infrequently seen in children of mothers who have had German measles (rubella) during the first trimester of pregnancy. When there is symmetry of involvement, such as bilateral, equal paralysis of the arms or legs, one should suspect a prenatal background. Congenital athetosis may cause a most difficult labor; this is more likely than that the birth trauma will result in the athetosis.

The *natal* group includes birth injuries. These are of two types: those resulting from direct mechanical injury, and those following prolonged anoxia. Mechanical injury may be due to incorrectly applied forceps (producing depressed skull fractures with subdural hemorrhage or cortical hemorrhage) and it may also follow failure to apply forceps in protracted labors. Excessive traction on the head will cause a tear of the tentorium and the vein of Galen, resulting in a basilar hemorrhage, and the clinical picture of the athetosis. Prematurity is an important factor in cerebral palsy. Here intracranial birth hemorrhage is due to the rupture of delicate and incompletely developed vessels by the sudden drop from the high intrauterine pressure to atmospheric pressure during a rapid delivery. This sudden fall in pressure is responsible for hemorrhage in the vertex of the brain beneath the anterior fontanel, resulting in the characteristic spastic paraplegia.

Cerebral anoxia is believed by Phelps[3] and others to be a constant causal factor in cerebral palsy. The injudicious use of analgesics and anesthetics in the second stage of labor, passive congestion as a result of the umbilical cord being wrapped around the neck of the fetus, or as a result of prolonged resuscitation will produce anoxia. Often, there will be a history of prolonged periods of inadequate respiration and of apnea requiring administration of oxygen.

Postnatal cases are rapidly being recognized as an important etiologic group. Severe jaundice occurring during the first weeks of life associated with erythroblastosis fetalis and disturbances of the Rh factor has resulted in damage to the basal ganglia with the development of athetosis. Other important postnatal conditions may be skull fracture due to head injury, and severe convulsive seizures as in whooping cough. Of greatest importance, perhaps, is encephalitis. This commonly follows the exanthematous diseases and pneumonia in childhood.

In dividing the clinical types of cerebral palsy into five main groups, the basis of denomination is the predominant clinical manifestation. In the true spastic child the characteristic findings are hyperirritability, hypercontractility and hypertonus of the muscles involved. These muscles exhibit the "stretch reflex" like the contraction of the antagonist in flexing a joint which produces stretching of the hypercontractile muscle involved causing it to contract and block the motion to a greater or lesser degree. Thus, in a spastic quadriceps, an attempt actively to flex the knee will cause

1. Ford, Frank R.: *Diseases of the Nervous System in Infancy, Childhood and Adolescence.* Charles C. Thomas Company, Springfield, Illinois, 1946.
2. Phelps, Winthrop M.: Archives of Physical Therapy, 22:587 (1941).
3. Phelps, Winthrop M.: Archives of Physical Therapy, 23:332 (1942).

an immediate contraction of the quadriceps blocking the effort to flex the knee. Thus the function of the spastic muscle with regard to its ability to contract is not impaired. The deep tendon reflexes are likewise hyperactive and clonus may be present, the clonus representing an exaggeration of the stretch reflex. Because of the location of the lesion (involving both areas 4 and 6 of the brain) there will be a mixture of muscular dysfunction, spastic muscles, flaccid muscles and normal muscles in the same patient. This combination causes the imbalance of muscle power which characterizes this group of the cerebral palsied.

The athetoid child shows involuntary motions of no constant pattern which attempt to move joints rather than individual muscles. The damage to the basal ganglia results in an abnormal release of voluntary impulses. The movements may be rapid or slow, constant or intermittent, and usually disappear during sleep. Phelps[4] has subdivided the athetoids into eleven types, designated by their outstanding clinical findings. They are: non-tension, tension, slow, rapid, shudder, pitch cut-off, flail, dystonic, tremor, rotary, head and shoulder athetoids. Athetosis may involve one or all of the extremities as well as the muscles innervated by the cranial nerves. Thus the facial muscles and muscles of speech may be involved. The constant grimacing and facial distortion has, in the past, led to an incorrect diagnosis of mental retardation.

The ataxias show a hypo-irritability of muscles, lack of muscle tone and a disturbance or loss of kinesthetic sense and balance. Because of the hypotonus, they may be late in walking. The tongue may be involved in the ataxia and the speech may be thick and dragging. There often is an associated nystagmus. These children may complain of nausea and dizziness from attempts at close fixation of the eyes in reading. Spontaneous improvement is better in this group than in any of the other types of cerebral palsy.

The "rigidity" child presents a loss of elasticity of the muscles which give a "plastic" or "lead pipe" response to passive motions of a joint. There is no true stretch reflex in the muscles. The rigidity may be intermittent or constant. Deep tendon reflexes are variable. Because of the diffuse involvement of the brain, the incidence of mental retardation in this group is relatively high.

The tremors are rarely the result of congenital or traumatic factors, but usually are acquired as a result of post-natal encephalitis. Tremors are characterized by involuntary motions which are reciprocal in nature and regular in rhythm. They may be divided into two types: (1) intention tremor, in which contractions occur only on "willed" motion, and (2) non-intention tremors, in which the contractions are present at all times and without effort.

31 Lincoln Park

WOUND INFECTIONS

Open surgical wounds infected with hemolytic streptococci, *Staphylococcus aureus*, or *albus* often heal when tyrothricin is applied in wet dressings after Dakin's solution, sulfonamides, penicillin, or other agents have failed. Gram-negative organisms are not affected. Kozoll uses a 2.5 per cent alcoholic solution of tyrothricin in sterile ampule, with concentration of 1 mg. per cubic centimeter. Blood supply and drainage must be adequate. —*Surg., Gynec. and Obst. 83:323.*

SALIVARY ADENITIS

Nonspecific infection of the salivary glands usually subsides under treatment with Lugol's solution. Altemeier starts medication within twenty-four hours of onset. The daily dose is 250 minims; 20 minims may be given orally every three hours and 60 minims in 1500 cc. of physiologic saline solution, injected subcutaneously, intravenously, or rectally. Abscess developing before or during treatment should be incised and drained and calculi removed.—*Surgery 20:191.*

4. Phelps, Winthrop M.: New York State Journal of Medicine, 41:1 (1941).

SPINAL ANALGESIA IN OBSTETRICS

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During the past decade the alleviation of pain in obstetrics has become more than just a wishful dream on the part of the parturient patient. Today it is a reality. Today the pregnant woman expects some scientific aid in the diminution of her discomfort while in the process of active labor. It takes a great deal of courage on the part of the physician to stand by and observe a laboring patient, writhing in pain, without taking advantage of some of the newer approaches of painless childbirth.

Corning[1] was the first to inject an anesthetic drug into the human spine. He introduced cocaine into the subarachnoid space of a patient suffering from spinal weakness and seminal incontinence, and described his technic for the relief of certain severe pains. This was in 1888. Kreis, in 1900, was the first to report the use of spinal anesthesia in obstetrics. Pitkin and McCormack,[2] advocating the use of spinal anesthesia in obstetrics in 1928, attempted to confine the agent to the sacral segments of the cord, thus producing a saddle type of distribution. Cosgrove,[3] has reported the largest series, 1788 cases, of deliveries under spinal anesthesia. In 1946, Parmley and Adriani[4] described saddle block anesthesia with nupercaine in 100 obstetrical patients.

The present report is the result of the use of spinal analgesia in 600 obstetrical cases. The first patient received her spinal block in August, 1946. Heavy nupercaine, 1:200, was the agent used in 150 patients, while pontocaine - glucose - ephedrine combination was administered to the remaining 450 subjects.

The usual contraindications that apply to surgical patients should be followed in the use of spinal analgesia in obstetrics. In addition, any condition that does not warrant a vaginal delivery in the practice of good obstetrics automatically contraindicates the use of spinal analgesia. The following is a list of general contraindications to the use of obstetrical spinal analgesia.

1. Disproportion of pelvic and fetal diameters.
2. Placenta previa, abruptio placenta, and non-engaging part.
3. Gross deformities, or diseases of the spine or central nervous system.
4. Hysterical and emotionally unstable personalities.
5. Local skin infections involving area of entry of needle.
6. Hypotension.

The advantages of spinal analgesia in obstetrics are as follows:

1. Relief of pain.
2. Relaxation.
   a. Shortened first stage of labor.
   b. Facility of manual rotation of arrested positions.
   c. Easier manipulation of breech extractions (with supplementary general anesthesia, if necessary).
3. Cooperation of patients.
4. Improved technic by quietude of posture.
5. Use of minimal amount of sedation and general anesthesia.
6. Lack of undesirable effects on fetus.
7. Painless examinations.

Spinal analgesia in obstetrics is never instituted unless the patient is actively in labor. The only exception to this rule is a caesarean section. The frequency and the intensity of the uterine contractions are important criteria in determining when the analgesia should be started. Dilatation, effacement, and descent of the presenting part are factors to be taken into consideration. As a general rule of thumb, the spinal is given when the primiparous patient is 3 to 3½ fingers dilated, effacement is present, and contractions occur every 3 to 4 minutes. With a multiparous patient, 2½ to 3 fingers of dilation, moderate effacement, and contractions every 4 to 5 minutes indicate the use of spinal analgesia.

The spinal taps were performed with the patient in the sitting position in bed. The needle was injected into the lowest and most prominent lumbar interspace. The time it

* From the Departments of Anesthesia and Obstetrics, Barnert Memorial Hospital, Paterson, N. J. Read before Section on Anesthesiology, Annual Meeting of The Medical Society of New Jersey, April 29, 1948.

1. Corning, J. L.: Medical Record, 33:291 (March 17, 1888).
2. Pitkin, G. P., and McCormack, F. C.: Surgery, Gynecology and Obstetrics, 22:763 (November 1928).
3. Cosgrove, S. A.: American Journal of Obstetrics and Gynecology, 22:763 (December 1931).
4. Parmley, R. and Adriani, J.: Southern Medical Journal, 39:191 (February 1946).

takes for the anesthetic agent to fix in the spinal fluid varies with different individuals. Patients are not kept in the upright position for any fixed time, but are immediately placed supine, with head and shoulders on two pillows. With the advent of the first uterine contraction without pain the head of the bed is elevated to a semi-fowler's position.

The dose of pontocaine varies from 3 to 5 milligrams, depending upon the estimated duration of labor. In addition 0.5 cubic centimeters of 10 per cent glucose and the same amount of a solution of ephedrine sulphate (grains 3/8) were added. The glucose assures a hyperbaric solution, while the ephedrine prolongs the duration of analgesia. The total volume of analgesic mixture never exceeds 1.5 cubic centimeters. There is no barbotaging of the mixture with the spinal fluid.

The dose of nupercaine is 2.5 milligrams, that is 0.5 cubic centimeters of a 1:200 solution. The addition of glucose further assures hyperbaricity. Ephedrine has only been added recently to our cases and is not included in this report.

Food was withheld from all patients who had received spinal analgesia. Routine catheterization was done prior to all deliveries.

The duration of analgesia in this series of cases is indicated below:

Uterine contraction pain: 40 to 180 minutes with nupercaine and 50 to 160 minutes with pontocaine.

Perineal pain: 2½ to 6 hours with nupercaine and 2½ to 4 hours with pontocaine.

Onset varied from almost instant analgesia to extreme cases where ten minutes elapsed before alleviation of pain was complete. Keeping the patients in a sitting position for a fixed period of time will in many instances cause the anesthesia to fall short of the desired level, and hence will result in incomplete pain relief. By the same token, high level anesthesia may develop in those patients who show a delayed fixation of the analgesic drug.

In our series, there were 222 primiparous and 378 multiparous patients. The table below shows the various presentations and positions as reported by the obstetricians:

Presentation	Cases	Ratio
ROA	180	30 %
LOA	265	44 %
ROT	18	3 %
LOT	34	6 %
ROP	32	5 %
LOP	50	8 %
Brow	2	0.3%
Face	1	0.16%
Breech	18	3 %
Cephalic	579	96 %
Not cephalic	21	4 %
Total	600	100 %

Methods of delivery are indicated in the table below. The high ratio of mechanical interference with labor is due to diminution of uterine expulsive power. Another factor may be the obstetrician's desire to terminate labor before return of uterine contraction pain. In such cases, good obstetrical judgment is imperative to obtain best final results from this type of analgesia.

Delivery	Number	Ratio
Spontaneous	56	9.3%
High forceps	6	1 %
Mid forceps	27	4.5%
Low and outlet forceps	490	81.7%
Breech extraction	18	3 %
Version and extraction	3	0.5%
Total	600	100 %

Although repeat spinals may be given, the ideal situation exists when one injection outlasts the stages of labor. When the patient is ready for delivery, and spinal analgesia is beginning to wear off, supplementary general anesthesia is used. This is discontinued with the termination of the second stage, as the expression of the placenta and the perineal repair can always be done painlessly. Of the 600 patients in this series, 63 received supplementary general anesthesia. Repeated spinal injections were done in 32 patients, of whom 30 received two blocks each, while two received three blocks each.

The drop in blood pressure following spinal block in this series of cases varied from 5 to 15 millimeters of mercury. Vasoconstrictors were not used routinely. Eighteen patients received ephedrine sulphate, grains ¼, subcutaneously, because of systolic pressures rang-

ing between 75 and 90 following the spinal injection. Two of the patients had a marked cardio-vascular depression which necessitated ephedrine intravenously, oxygen by inhalation, and intravenous fluids. Both rallied quickly, delivered, and made uneventful recoveries. During the course of spinal analgesia, untoward reactions should constantly be borne in mind. There is no excuse for not having available the necessary drugs, equipment, and knowledge to combat the cardio-vascular and respiratory emergencies that might possibly arise. Oxygen, intravenous fluids, ephedrine, plasma, and an endotracheal tray should be within arm's reach at all times.

Spinal analgesia does not seem to increase the incidence of post-partum bleeding, nor does it appear to delay the separation of the placenta. Pituitrin and ergotrate are as effective on patients under spinal analgesia as on patients who have received other types of anesthesia.

How does infant mortality in spinal anesthesia deliveries compare with the mortality when other methods of anesthesia are used? In the past two years, there were 1211 deliveries at the hospital. Fourteen resulted in still births; there were 21 neonatal deaths. Total infant death rate varied from 3.3 per cent when no anesthesia was used, down to 1.6 per cent with spinal anesthesia. These figures are derived from the following table.

Anesthesia	Cases	Still Births	Ratio	Neonatal Deaths	Ratio	Infant death rate
Spinal	600	4*	0.6%	6	1.0%	1.6%
General	334	5*	1.5%	11	3.2%	4.6%
Caudal	159	2	1.2%	3	1.8%	3.0%
None	118	3	2.5%	1	0.8%	3.3%
	1211	14		21		

* Two of these patients received spinal anesthesia plus general anesthesia.

The ratio of still births and neonatal deaths is lowest among patients who received spinal analgesia. The table includes all still births and neonatal deaths in premature infants weighing more than three pounds at birth. The neonatal period included the first seven days of life. When spinal analgesia is administered properly there should be no increase in infant mortality rate as compared to other types of anesthesia employed. When this rate rises, it is due to poor obstetrical management. We advocate the use of spinal analgesia only among patients whose deliveries are being handled by physicians with obstetrical experience.

There was one maternal death in this series. The case is summarized below:

A 32 year old gravida VII para V, was admitted to the maternity ward without any pre-natal care. Her last menstrual period was December 9, 1946, and the expected delivery date was September 16, 1947. The patient had an enormously enlarged abdomen. Fetal heart could not be heard. Vaginal examination revealed no dilatation of the cervix and no presenting part. A diagnosis of polyhydramnios was made. X-ray revealed an anencephalic fetus. The patient had mild edema of lower extremities, blood pressure was 132/90. On September 17, examination revealed 4 fingers dilatation with irregular uterine contractions. She was taken to the delivery room at 11 a. m. Spinal analgesia was administered at 11:20 a. m., using pontocaine 4 milligrams, ephedrine 0.5 cubic centimeters, and 10 per cent glucose. The analgesia was effective. At 11:40 a. m. the membranes were ruptured and six litres of amniotic fluid was slowly drained out. At noon an internal podalic version was done, and the legs, thighs, and buttocks delivered with difficulty. It was observed that a spina bifida was present, which impinged under the symphysis. A general anesthesia (chloroform and ether) was then administered to obtain relaxation of the uterus. While the fetus was being extracted (with extreme difficulty) it was observed that the pulse was unobtainable, and respirations suddenly ceased at 12:30 p. m. All attempts at resuscitation failed. The patient was pronounced dead at 12:50 p. m. No post-mortem was obtained.

In view of the fact that this patient maintained good general condition an hour after the spinal injection, it is difficult to believe that the spinal analgesia was responsible for this death.

Since the first spinal analgesic in obstetrics at our hospital 18 months ago, the only anesthetic complication has been the incidence of

post-spinal headaches. Maintaining the patients flat in bed for 12 hours and then *gradually* elevating the head, a few degrees at a time, keeps this complication at a minimum.

In nupercaine analgesia, 17 per cent of the mothers suffered from post-spinal headache. In pontocaine analgesia, the figure was only 10 per cent. We believe that there is a distinct difference in the type of headache that complicates the use of these two drugs. The headache following nupercaine is more intense, lasts longer, is more disabling and more difficult to relieve than that following the use of pontocaine. Aspirin, caffeine, and nicotinic acid (100 milligrams) intravenously were used to treat this condition, but as yet no one drug has been found consistently effective.

In comparing the relative efficiency of the two drugs (nupercaine and pontocaine), we are including some of our observations which are listed in the table below:

Pontocaine	*Nupercaine*
1. More intense motor paralysis of lower extremities.	1. Less intense.
2. Frequency of nausea and vomiting slightly increased.	2. Nausea and vomiting slightly less.
3. Less duration from uterine contraction pain.	3. Longer duration.
4. More complete analgesia, as exhibited under forceps deliveries.	4. Less intense analgesia.
5. Lower incidence of headaches — less incapacity.	5. Higher incidence of headaches — more incapacity.

SUMMARY

A series of 600 vaginally delivered obstetrical cases using spinal analgesia is presented. This type of analgesia seems warranted in the routine vaginal delivery, in the practice of good obstetrics, when no existing condition contraindicates the use of a subarachnoid block. Primary advantage of this procedure is the alleviation of pain. The high ratio of forceps deliveries significantly shows the diminution of expulsive power on the part of the patient. Although it has been our policy to institute spinal block when one injection would extend through the second stage of labor, repeated blocks were performed in about 5 per cent of the cases. In addition, 10 per cent of the patients received supplementary general anesthesia.

With the exception of post-spinal headaches, there have been no anesthetic complications in this series. Infant mortality studies show a significantly diminished still birth and neonatal death rate as compared with other obstetrical pain relieving methods. There was one maternal death, but it is believed that the use of spinal analgesia was not a major contributing factor.

An appraisal of the relative efficiency of pontocaine and nupercaine is included.

The incidence of post-spinal headaches has been persistent. Maintaining the patients flat in bed for 12 hours following delivery and then gradually elevating the head, a few degrees at a time, keeps this complication at a minimum.

CONCLUSIONS

By means of spinal analgesia in obstetrics, the alleviation of pain can be obtained with a minimum of discomfort to the patient and a wide margin of safety.

681 Broadway
577 Broadway

MULTIPLE PHLEBITIS

Inflammation may involve a vein, subside, and then appear in another vessel. Unless adequately treated, thrombo-angiitis obliterans is inevitable. Smoking and vasoconstricting effects of cold water must be eliminated. In early stages, Ficarra relieves pain and hastens recovery by venous compression at regular intervals. During an acute attack an Ace bandage is applied and the patient may be put to bed with legs elevated, dry heat to the involved areas, and chemotherapy. Lumbar sympathectomy is indicated in deep migratory polyphlebitis when pain, tenderness and edema are considerable.—*Arch. Surg. 53:105.*

ACNE VULGARIS

S. A. Klein, M.D., Morristown, N. J.

The problem of acne vulgaris is likely to continue to concern all practitioners who encounter this complaint. Its onset is usually indeterminable, although occasionally several members of one family may report having been affected with this eruption during one part of their adolescence. Acne vulgaris is practically limited to this period of maturation. Occasionally, unusual types may be seen in children, rarely in parturient patients, and also in the third decade in women. This last type has specific localization about the chin.

The degree of involvement varies from the minutest comedone acne, to a cystic type which is nearly always followed by excessive scarring.

Systemic therapy has numerous advocates who also can report a reasonably large number of failures. The appearance of acne during the adolescence has been attributed to endocrine and hormonal changes, yet therapies directed towards this goal have been largely unsuccessful.

Dermatologists prefer to utilize physical agents though there are continuing efforts to use adjuvant aids in the form of vitamins, thyroid, diet, and tuberculin, to mention only a few of a galaxy which find proponents everywhere. The fact that failures are manifest should be ample proof of the final inadequacy of any one, or series of methods used alone or together.

What is the role of diet? Patients will confirm flare-ups following excessive ingestion of highly seasoned foods, or cooked sugars, yet restrictive diets are often futile. Dermatologic opinion is divided concerning the efficacy of diet therapy. Naturally, an excessive consumption of any richly prepared articles of diet should be discouraged, but permission to eat the regularly prepared foods of a normal household will find approval from several members of the family, as well as from the patient.

Well established cases of acne persist over several seasons, and usually are characterized by an eruption which is peculiar to the patient. Thus a minute papular type of acne when it relapses or recurs will return as a minute papular type. Seasonal fluctuations are questionable; general exacerbations have been recorded by dermatologists at periods when others have noted spontaneous remissions.

It is currently popular to seek for psychosomatic factors in disease, and this is true of acne, which is commonest at a critical period in life. The challenges (both mental and physical) to which the maturing boy and girl are subjected can be troublesome. It is not difficult to find instances of flare-ups following unusual strain, or emotional stress. Readjustment with adolescents, as with all individuals is continuous. Often, however, no questioning can evoke complaints in this sphere. Are we entitled, therefore, to assume the existence of underlying unspoken tensions which may be related to this process? The answer depends upon realizing the fact that this may be true of *any* illness. Ordinarily then, aside from frank emotional out-spoken tensions, intervention in this sphere is undesirable.

Occasionally, acne becomes an additional cause for anxiety, and in such instances, it may lead to the patient's withdrawal from his usual social activities. With local improvement, therefore there may be a coincidental recovery of interest in social obligations. Whatever local therapy may be selected, whether this be heliotherapy, roentgen therapy, peeling lotions, peeling paste, or sulfur, plus manual removal of comedones, it is well to bear in mind that inflammatory papulès on the face frequently are associated with disruption of some elastic fibres. When resolution is present, some pitting will result which is independent of any therapy. This is a variable by-product of the process, and is erratic in its appearance for some patients will pit with very small lesions, whereas the converse need not be marked. Tendencies in this direction are easily visible to inspection prior to institution of any plan of therapy.

11 High Street

THE RECOGNITION AND MANAGEMENT OF EPILEPTIC SYNDROMES

Ira S. Ross, M.D., Newark, N. J.

The term 'epilepsy' to physicians and laymen alike still has vague and ominous connotations. So often a mother states, "Doctor, my child has had three convulsions" and then asks, "Does he have epilepsy?" Frequently the referring physician says, "This patient has two generalized convulsions per year at night with tongue biting and incontinence. You report that his electroencephalogram is normal. Does that mean he does not have epilepsy?" Or again, an interested uncle of a twelve year old boy states, "The boy has had only a few falling spells and bit his tongue a couple of times. You reported that he has a paroxysmal cerebral dysrhythmia in the electrogram and said that these findings are indicative of a genetically determined disposition to convulsive disorder. Does that mean he has epilepsy? We do not have epilepsy in our family."

Epileptic disorders may be divided into two major groups. In the first group (symptomatic epilepsy) the seizures are secondary to recognizable cerebral pathology. In the second group anatomic changes are not demonstrable and the condition is termed "idiopathic". Cerebral trauma, neoplasms and the encephalitides, particularly those accompanying measles and pertussis, are frequently provocative of "symptomatic epilepsy". In the idiopathic epilepsies recent work[1] indicates that hereditary factors are important.

The physician must direct his thinking to the *brain* of the patient with complaints of interruption of the state of consciousness, fleeting peculiar sensory experience, localized and generalized convulsive phenomena and episodic periods of aberrant behavior, usually of stereotyped manner and followed by amnesia. In those cases he must do a neurologic examination and follow this with routine anterior-posterior and lateral skull films, electroencephalography and, where indicated, recommend lumbar puncture for cerebrospinal fluid evaluation and pneumoencephalography or ventriculography.

The effort expended in studying the patient with seizures is not a matter of merely academic interest. We have at our disposal a small but diversified pharmacologic armamentarium. It may reasonably be expected that newer improved drugs will soon be in the physician's hands. The present list includes such drugs as phenobarbital, diphenyl hydantoin (dilantin), methyl-phenyl-ethyl-hydantoin (mesantoin), methyl-ethyl-phenyl-barbituric acid (mebaral), trimethyloxazolidine — dione (tridione), levo and dextro amphetamine (benzedrine and dexedrine), as well the specific medications such as penicillin and the sulfa drugs where the seizure announces the onset of a fulminating paresis or other cerebral inflammatory condition. The proper use of these pharmaceuticals depends upon proper diagnosis.

PETIT MAL

Perhaps the first seizure symptom complex that became important to categorize independently is "petit mal epilepsy" or pyknolepsy. "Petit mal," contrary to what the name would imply, is not just any little fit. A host of other small seizures must be excluded from the category and treated entirely along different lines, most often by different drugs. Petit mal epilepsy has been well defined[2] as follows:

> "Petit mal is used in a restricted sense to mean a transient lapse of consciousness (usually five to twenty seconds) without tonic spasm; if convulsive movements are present, they consist of rhythmic, approximately three per second clonic jerking of the eyelids, head or arms. This type of seizure is sometimes referred to as pyknolepsy or better pyknoepilepsy. Some clinicians have applied the term "petit mal" to any form of seizure which is short or mild. Used in this way the term lacks specific meaning; it refers not to the type but to the severity of the seizure. Such a use of the word obstructs discussion of the subject."

Elsewhere, Lennox[3] says:

> "The patient may drop what he has in his hands,

1. Lowenbach, Hans. Bulletin of the Johns Hopkins Hospital, 65:125 (July 1939).
2. Gibbs, F. A., Gibbs, E. L. and Lennox, W. G.: Archives of Neurology and Psychiatry, 104:247 (August 1943).
3. Lennox, W. G.: *Science and Seizures.* 2d Edition, Harpers, New York, 1946.

but he rarely falls and many patients can continue to walk, to swim or even to ride a bicycle during an attack. Consciousness is regained abruptly and fully without unpleasant after symptoms. In spite of its transience the patient ordinarily knows that an attack has occurred."

In "petit mal epilepsy" the electroencephalogram is specifically diagnostic in eighty-five per cent of all cases.[2] In the interim between seizures, eighty-five per cent of patients with petit mal show runs of three per second alternating wave and spike pattern, i.e., the pattern which occurs during a clinical petit mal seizure or runs of two per second alternating wave and spike pattern, the petit mal variant. This is well displayed in Figure 1. The basic pattern of the records between these spike and wave paroxysms may be irregular or normal.

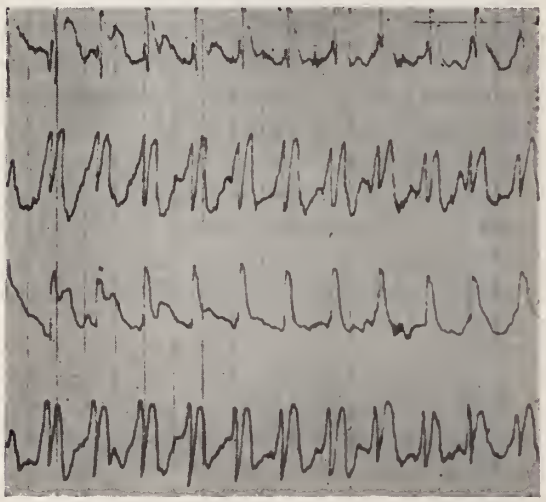


Figure 1. Electroencephalogram showing petit mal type of activity.

The presence of the petit mal syndrome in a patient does not exclude the occurrence of grand mal seizures in the same patient. Children with petit mal may develop grand mal seizures as they grow older. The importance of differentiating petit mal and establishing the specificity of the diagnosis is that medical treatment of petit mal is a specific one. Tridione has a selective efficacy for petit mal whereas other medications used in the treatment of the epilepsies occasionally make petit mal worse.[4, 5, 6, 7] The difference in the therapeutic effectiveness of tridione in petit mal and phenobarbital or dilantin in grand mal may rest on the difference in site of action of these drugs. There is evidence [4] that the seat of the disorder in petit mal is the thalamus [8] or hypothalamus. The electroencephalograph in this disorder has a specificity of clinical diagnosis rarely to be met in a laboratory test. Furthermore, the laboratory findings in petit mal give specific indication for the use of tridione alone or in combination with phenobarbital in cases with both grand mal and petit mal seizures.[4]

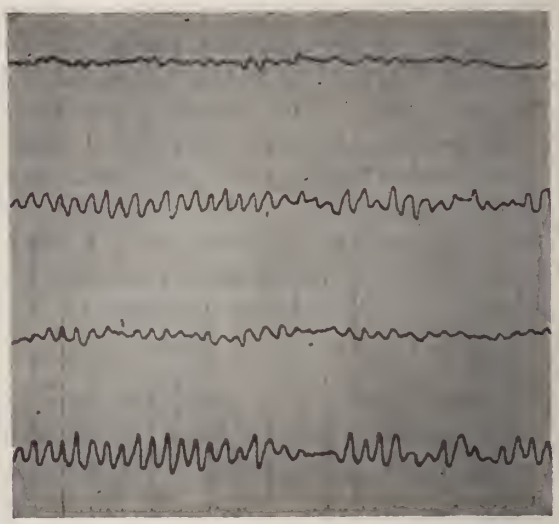


Figure 2. Electroencephalogram showing normal brain waves.

ELECTRICAL BRAIN RHYTHMS

When we turn our attention from petit mal epilepsy to other epileptic disorders we encounter more complicated clinical questions. Before proceeding further it becomes necessary to explain a few fundamentals of electroencephalography.

The normal adult brain waves are cortical potentials recorded the way the electrocardiograph records the action potentials of the heart. In the brain, the frequencies range from 8 to 12 per second. A normal pattern is illustrated in Figure 2.

Various cerebral disorders disturb the normal electro-cortical rhythm and the resultant findings are termed *dysrhythmias*. When these abnormal interruptions occur abruptly and intermittently

4. Pearlstein, M. A.: American Journal of Psychiatry, 104:247 (October 1947).
5. Richards, R. K.: Archives of Neurology and Psychiatry, 55:164 (February 1946).
6. Pearlstein, M. A.: Archives of Neurology and Psychiatry, 55:174 (February 1946).
7. Lennox, W. G.: American Journal of Psychiatry, 103:159 (September 1946).
8. Hursh, J. B.: Archives of Neurology and Psychiatry, 53:274 (April 1945).

they are called "paroxysmal dysrhythmias". In petit mal the typical dysrhythmia is characterized by paroxysms of alternating spike and wave formations (Figure 1) at the rate of three per second with minor variations. These abnormal cortical discharges in petit mal cannot include the motor neurons as no motor phenomena are encountered in the usual petit mal attack. This is one of the considerations that Hursh [8] made when postulating the thalamus or hypothalamus as the site of the cerebral pacemaker in the petit mal discharge.

In contrast, a cardinal feature of the grand mal attack is clinical and electrical discharge from the cortical motor neurons. During the tonic phase of the generalized convulsion, high amplitude spike forms at the rate of approximately thirty per second are recorded from all regions of the cerebral hemispheres. This is illustrated in Figure 3. Be-

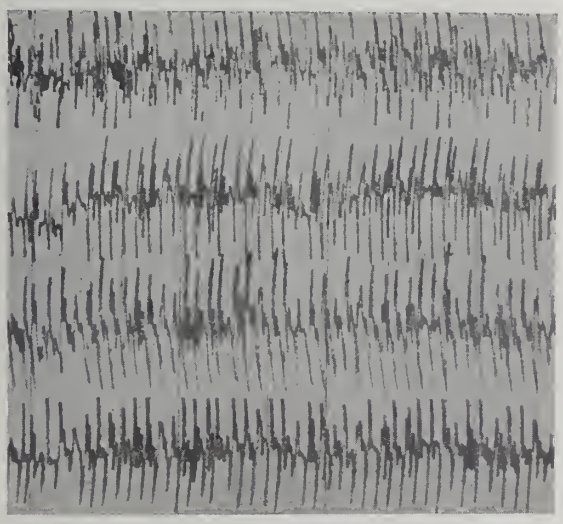


Figure 3. Electroencephalogram showing grand mal type of activity.

cause this type of cerebral electrical activity occurs during every grand mal seizure it has been called [2] the grand mal pattern. The clinician should realize that this specific type of activity is rarely recorded in the intervals between attacks.

"IDIOPATHIC" GRAND MAL EPILEPSY

The diagnosis of major epileptic seizure is not difficult.[9] However, it is not so simple to determine whether the seizure is due to an acquired cause or has to be classed as "idiopathic" or primarily hereditarily determined. A spell may or may not be preceded by prodromal symptoms lasting hours or days including such variations as myoclonic twitchings, headaches, vertigo, fleeting visual and auditory phenomena, hypalgesias, gastro-intestinal symptoms from nausea to ravenous appetite or mood disturbances. There may be a preceding aura, a momentary sensation or premonition (so varied as to be almost peculiar to each individual patient) that precedes the fit by a few seconds. The aura are phenomena like those that can be induced by artificial cerebral stimulation varying from brief sensations to more complex sensory experiences and movements. The loss of consciousness that precedes the convulsion may occur without prodrome or aura just as it does in the electrically induced therapeutic convulsion. There may or may not be a cry as the patient falls and passes into a state of tonic rigidity, wherein posture is determined by the differences in strength and mechanical advantage of the patient's musculature. The jaws clench, the fingers flex at the metacarpo-phalangeal joints frequently with the thumb between first and second finger. The forearms tend to pronate, the elbow joints are semi-flexed and the arms rotated inward at the shoulder. The trunk tends to flex. More rarely the trunk and head assume a mild opisthotonus. However, in epilepsy I have never seen the degree of opisthotonic posture assumed during the fit of major hysteria. In men the lower extremities usually extend, in women they frequently assume the coitus posture. After a few seconds to a minute, alternate relaxations and contractions mark the clonic phase that often terminates with a final click of the jaws on the bitten tongue, cheeks or lips. Frequently evacuation of the bladder and bowels ensues. With a deep sigh the livid subject begins a stertorous hyperpnea and passes into sleep and returning consciousness. Sequelae may include automatic behavior, confusion, malaise, nausea, headache, violence, depression or lassitude. When the attack is not seen, the evidences or injury in falling, the bitten tongue, the perspiration soaked and soiled clothing give convincing evidence of what has occurred. Seeing an attack, hearing the description or discovering the bruises, bitten tongue or soiled clothing is sufficient evidence for a diagnosis of grand mal epilepsy. If an electroencephalogram is taken at the time of an attack the characteristic high amplitude, (twenty to thirty per second

9. Wilson, S. A. K., and Bruce, A. N.: *Neurology*. Williams and Wilkins, Baltimore (1940).

spikes) are recorded from all regions of the cerebral cortex. Following the convulsion, while the patient is still unconscious, large slow wave forms are recorded as in any state of coma [10] and with returning consciousness the cerebral electrical activity returns to the interseizure pattern. In fewer than 2 per cent of patients who had only grand mal attacks (and no other type of seizure) was this type of activity recorded in intervals between seizures by Gibbs, Gibbs and Lennox.[2] In this category, 42.5 per cent of the routine records [2] taken showed severe enough abnormalities to make the brain wave record helpful in establishing the diagnosis of epilepsy. Eighteen per cent of the records taken of these patients were entirely normal in the intervals between attacks. Thus, *more than half of the electroencephalograms taken in patients during the interval between major seizures may turn out to be normal* or so slightly abnormal as not to be diagnostically helpful. Other workers [11] have reported twenty per cent normal records in these cases. A normal record does not mean that the patient does not have epilepsy. It means that the presence of an expanding intracranial process is not a likely cause of the patient's convulsions. Cerebral neoplasms give accurately localizing electroencephalographic findings [12] in 50 to 76 per cent of cases. Abbot [11] studied patients having had major seizures who had normal electroencephalograms. He found that they had seizures later in life, had relatively fewer seizures, in general required less medication and tended to have better occupational histories and better prognoses.

The drugs of choice in treatment of grand mal epilepsy are phenobarbital and dilantin or a combination [13] of the two. Since phenobarbital is the less toxic of the two, it should be tried first in small doses; ½ grain for adults, repeated during the day and at bed time before using dilantin. The adult dosage of dilantin sodium is 1½ grains three times daily. This may be increased to four or five 1½ grain capsules daily providing the patient does not develop toxic symptoms. In my experience, a daily intake of less than 4½ grains is usually ineffective for adults.

JACKSONIAN EPILEPSY

The jacksonian seizure is a special form of convulsion in which the patient retains consciousness while the convulsive jerkings start at one part of the body and progress in a "march". The seizure spreads in the distribution of the cortical representations of the affected body area. Thus, frequently a jerking starting in a thumb will next affect the side of the mouth on the same side of the body, as the mouth and thumb motor areas lie adjacent to each other on the cortex. If this type of seizure spreads to the other side of the body, consciousness is usually lost. Jacksonian epilepsy is frequently associated [9] with focal pathologic findings in the cortex such as meningioma, focal infarction and scarring, vascular abnormalities, abscess or laceration. Walker and Johnson [14] disagree with this statement insofar as they state, "A true jacksonian seizure is not often seen in symptomatic epilepsy". The electroencephalographic findings associated with the jacksonian type of seizure consist of what Lennox and Gibbs have termed the "grand mal" pattern of seizure discharge. In this instance [15] the spiking starts at the focus of cortical representation of the initial part affected by jerking and spreads over the cortex as the seizure advances. This pattern of discharge takes the form of high amplitude, thirty per second spikes. A record illustrating the onset of such a seizure is shown in Figure 4. In "epilepsia partialis" the discharge does not spread but remains confined to one area of the cortex and the jerking remains confined to one portion of the body such as the side of the face, a thumb or a larger portion of an extremity. When the jacksonian type of discharge spreads from one cortical area to another it apparently spreads by contiguity rather than by conduction over the large association tracts of the white matter.

10. Williams, D.: Journal of Neurology and Psychiatry, 4:107 (February 1941).
11. Abbot, J. A.: Archives of Neurology and Psychiatry, 58:525 (October 1947).
12. Gibbs, F. A.: American Journal of Psychiatry, 102:527, (January 1946).
13. Merritt, H. H. and Putman, J. T.: Archives of Neurology and Psychiatry, 42:1053 (December 1939).
14. Walker, A. E. and Johnson, H. C.: American Journal of Surgery, 75:200 (January 1948).
15. Jasper, H. H.: *Epilepsy and Cerebral Localization* by W. Penfield and T. C. Errickson, Charles C. Thomas Company, Springfield, Illinois, page 416 (1941).

SYMPTOMATIC GRAND MAL EPILEPSY

What happens when a cortical focus of convulsion producing nature is not seated directly in the motor cortex? Penfield and Erickson [16] present evidence to show that some seizure discharges spread along the cortex by contiguity. Others, more complicated, apparently travel by "spread" along anatomically connected neural pathways, for example, from one hemisphere to the other through the corpus



Figure 4. Electroencephalogram showing in lead 1. a focus of grand mal activity accompanying jacksonian seizure.

callosum or from motor cortex to basal ganglia by way of the internal capsule, as well as by contiguity over the cortex. They also show that the "spread" of the cortical seizure discharge tends to travel toward the sensori-motor cortex in a fanwise manner. Thus, discharges producing visual aurae from the occipital lobe hit the sensori-motor cortex, if they travel that far, usually in an all inclusive, explosive manner and are accompanied by a generalized fit that may be initiated with a quick movement of one side of the body. The further the epileptogenic focus is from the sensori-motor cortex, the more likely is the seizure to be a generalized one. Thus a seizure that may start with a local cortical discharge, in a region remote from the sensori-motor cortex, appears clinically the same as a nonspecific grand mal attack. Should the patient have a degree of retrograde amnesia, as so often happens following any type of seizure, he may have an amnesia for his aura and thus not be able to give any evidence clinically of the focal nature of his seizure onset. Electroencephalography may be helpful in demonstrating the responsible focus in grand mal seizures wherein a lesion remote from the sensori-motor cortex is causative. Should the focal irritation be the result of a brain tumor, electroencephalography forms the first step in establishing the diagnosis.

SYMPTOMATIC PARTIAL SEIZURES

We now consider the cortical seizure discharge akin to the "epilepsia partialis" that occurs outside of the Rolandic cortical area. Take as an example the familiar case of seizures starting in the temporal lobe. Commonly, in this condition, the patient experiences an aura of a dreamy state or he might have auditory gustatory or olfactory hallucinatory experiences. This is often followed by champing movements of the jaws or sucking movements of the lips as the discharge spreads to the foot of the pre-Rolandic area. There then may follow stimulation of the frontal adversive eye field with turning of the head and eyes to the opposite side and/or the initiation of a generalized convulsion as the "spread" proceeds to basal ganglia and subcortical association fibers, corpus callosum and the opposite motor cortex. Such a sequence would be easily recognized as a seizure starting in the temporal lobe. If, as often happens, the seizure does not spread as described but fades out before becoming generalized, we witness then an aura and a brief champing fit. In a milder discharge there might result only the aura, that is, a momentary dreamy state, a *dejá vue* experience, a transitory taste, an odd smell that lasts but a moment, or a sound of babbling voices or ringing bells. It is then difficult to differentiate clinically, this phenomena from the true petit mal attack or from a psychologically determined hallucinatory experience. In these abortive seizures that are not petit mal, electroencephalography is most valuable. For the treatment of the "partial seizure", depend-

16. Penfield, Wilder and Erickson, T. C.: *Epilepsy and Cerebral Localization.* Charles C. Thomas, Company, Springfield, Illinois, (1941).

ing on its specific etiology, might be surgery, anti-luetic chemotherapy, or, if non-specific, phenobarbital, dilantin or mesantoin but not tridione. Tridione has practically no value in seizures other than petit mal; while the other medications frequently make petit mal worse. Momentary epileptic phenomena of this category should be called "partial seizures" to distinguish them from petit mal attacks.

PSYCHOMOTOR EPILEPSY

A psychomotor seizure is defined by Gibbs, Gibbs and Lennox [2] as a period of impaired

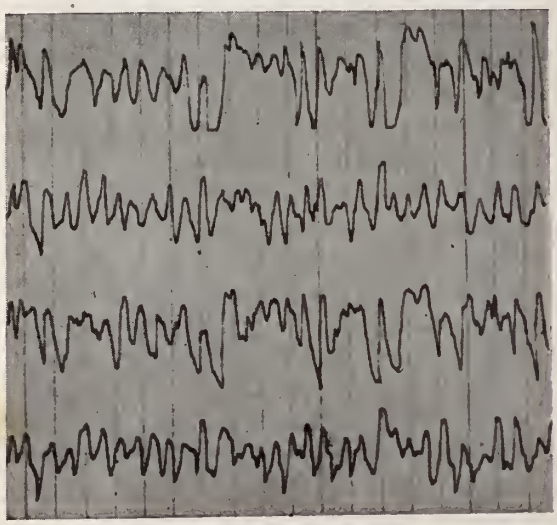


Figure 5. Electroencephalogram showing type of activity associated by Gibbs and Lennox with the psychomotor attack.

consciousness or amnesia with apparently purposeful movements, sometimes accompanied by manifestations of emotional excitement, particularly fear or rage. The psychomotor seizure is accompanied by cerebral electrical disturbances [2] recorded as flat topped four per second waves together with high voltage six per second waves or discharges of irregular positive spikes. This is illustrated in Figure 5. Gibbs and Lennox found this type of record in 42 per cent of patients with psychomotor seizures only. Whether psychomotor seizures alone deserve a separate category (as implied by the term "psychomotor epilepsy") is open to question. The significance of the brain wave pattern is doubtful. Jasper,[15] reported that in about half the patients with this form of electroencephalogram behavior automatisms were not prominent. Löwenbach and myself failed to find a single instance of electroencephalographic and clinical correlation in the diagnosis of psychomotor epilepsy in two thousand consecutive routine tests taken for all inclusive diagnostic purposes at Duke Hospital in the years 1941 to 1943. Nevertheless, Kozol [17] has reported that mesantoin has a specific therapeutic effect on psychomotor seizures and for this reason the clinical differentiation is important. However, Lennox [7] did not report as enthusiastically, and De Jong [18] finds that tridione used either alone or—(better)—in conjunction with dilantin and phenobarbital is helpful in the control of psychomotor seizures.

SUMMARY

1. The major forms of epileptic seizures have been described. Problems of differential diagnosis have been discussed. Etiologic considerations were reviewed briefly insofar as they might relate to therapy. Electroencephalography in case study is an adjunct that is helpful in ruling out the material that deserves further diagnostic study or surgery; and it also affords indications for the type of medication to be used.

2. Recent literature [13] indicates that phenobarbital and dilantin are the drugs of choice for grand mal seizures. Tridione has its greatest value in the control of petit mal seizures.[7] Mesantoin is alleged to have selective effectiveness for psychomotor seizures.[17]

3. Tridione used alone may make grand mal patients worse.[7, 18] Bromides or phenobarbital may increase the frequency of petit mal and psychomotor attacks.[18] Dilantin is of no value in the treatment of petit mal attacks when used alone.[7]

4. In combined grand mal and petit mal attacks, tridione combined with phenobarbital is superior to the combination of tridione and dilantin.[18]

5. In combined grand mal and psychomotor attacks the combination of drugs of choice would appear to be mesantoin and dilantin.[17]

17. Kozol, H. L.: American Journal of Psychiatry, 103:154 (September 1946).
18. DeJong, R. R.: American Journal of Psychiatry, 103:162 (September 1946).

6. The toxic effects of dilantin are drowsiness, ataxia and nystagmus and the undesirable side effects are hypertrophy of the gums and hirsutism. Toxic effects of tridione are rarely encountered. They range from mild visual disturbances (photophobia, blurring, changes in color, form and perception) or dizziness and morbilliform or fixed rashes to one reported case of transient amblyopia, several leukopenias and reports of a fatal aplastic anemia, and agranulocytosis with recovery.[18] Toxic effects of mesantoin include a morbilliform rash, fatigue, ataxia, gastric symptoms and sleepiness.[7] In patients on tridione, frequent checking of hemoglobin and blood cell counts is advisable. Phenobarbital may produce drowsiness, and rare patients develop a skin rash, but by comparison with the other anticonvulsants, phenobarbital is much less likely to produce unpleasant side effects. In epileptic disorders other than petit mal, phenobarbital remains the drug of choice for first trial. This is so because it rarely produces serious "side effects", it is especially safe in the nocturnal disorders of elderly people, small amounts are often effective in mild cases, and because the other drugs often have a high threshhold dose below which they are ineffective.

7. In petit mal, amphetamine and its isomers occasionally effect moderate improvement, but tridione is consistently beneficial and remains the drug of choice.

NOTE—The electroencephalograms reproduced here were recorded with an ink-writing electroencephalograph manufactured by the Electro-physical Laboratories, and applied in the standard manner, as diagrammed, using the Rahm electrode paste. Thanks are due to Miss Julia Atrochin for technical assistance in taking the records and for help in selecting the illustrations.

190 Clinton Avenue

HOLD THAT DATE

December 8, 1948—hold that date for the Fall Clinical Conference of The Medical Society of New Jersey. Come to Trenton then and you will be treated to one of the most stimulating refresher courses that has ever been packed into a single day. Five hospitals in Trenton are scheduling practical clinical programs in the morning. Luncheons will be available at the hospitals.

The afternoon sessions will be held at the Stacy Trent Hotel and the visiting physician will have his choice of programs on pediatrics, neuropsychiatry, gastro-enterology, thoracic diseases or cardiovascular diseases.

This will be followed by a general presentation of the problem of disability insurance.

The evening program opens with a cocktail party, and closes with a dinner at which Dr. Joseph H. Howard will deliver the Elias J. Marsh Oration on "The Physician As a Citizen".

Detailed programs will be mailed to all members in a few weeks. Save your copy and bring it to Trenton.

NEW JERSEY NEURO-PSYCHIATRIC ASSOCIATION

announces the

SECOND ANNUAL C. C. BELING MEMORIAL LECTURE

to be given by

HANS SELYE, M.D., Ph.D., F.R.S.(C)

Director of the Institute of Experimental Medicine and Surgery
University of Montreal

on

GENERAL ADAPTATION SYNDROME AND DISEASES OF ADAPTATION

at

The Academy of Medicine, 91 Lincoln Park, Newark

on

Wednesday, October 13, 1948 (8:30 P. M.)

STATE ACTIVITIES

WELFARE COMMITTEE

The first fall meeting of the Welfare Committee was held Sunday, September 19, 1948, with a total attendance of fifty-one of which twenty-nine were regular members of the committee. Dr. Vincent P. Butler, chairman, presided.

Film—"Human Growth"

At the request of the special committee on Public Health Week the film, "Human Growth", was viewed by the Welfare Committee for consideration as to the advisability of approving the film for showing during Public Health Week. The film has been described in Life Magazine and was prepared by the University of Oregon. It is designed for showing the school classes from the 6th to 9th grades, for teacher training, for adult groups, and for groups interested in child psychology.

The Welfare Committee recommended that the film, "Human Growth", be approved as a proper film for sex education and be distributed to the county societies for use during Public Health Week; the film to be restricted to the use of the county societies at their discretion during Public Health Week for showing to adults only at the places where exhibits are to be held.

National Physicians Committee

Dr. Londrigan, New Jersey Chairman of the National Physicians Committee, reported on the conference of physicians in Chicago, September 5, 6 and 7. He stressed the necessity of every physician taking part in the active campaign of the National Physicians Committee and in educating his patients to the dangers of socialized medicine.

The Welfare Committee recommended that The Medical Society of New Jersey reaffirm its endorsement of the National Physicians Committee and that it be suggested to the county societies that they make voluntary assessment upon their membership for support of the National Physicians Committee, such assessment to depend upon the membership of the individual county society.

Legislation

The Legislative Committee reported on the disposition of the various professional boards under legislation recently adopted, and of action taken on several other bills of interest to the Society. The Board of Medical Examiners has been placed in the Division of Professional Boards under the Department of Law and Public Safety. The committee's attention is now engaged on the following three propositions:

1. Assistance to the committee of five to be named by the Governor, (ACR-13) "to study and report to the Legislature upon the subject of licensing and regulating the practice of chiropractic".
2. Whether the licensing of psychologists by the state is desirable and necessary.
3. Legislation to provide for the licensing of commercial laboratories.

See page 510 for legislative activities.

Public Health Committee

A. The American Medical Association, under its Council on Medical Service, has established a program on rural health and there is no committee in the State Society which corresponds with this category to follow through on the national program at a state level. In addition to cooperating with the A.M.A. on their program, an Advisory Committee on Rural Health could also act in an advisory capacity to the Woman's Auxiliary on its rural health program and also promote interest in the rural areas for better local health protection.

The Welfare Committee recommended that the Board of Trustees authorize the establishment of a new Advisory Committee on Rural Health.

B. The Advisory Committee on Child Health met prior to the meeting of the Public Health Committee and presented the following three recommendations which the Welfare Committee approved:

(1) That the Academy of Pediatrics and the Bureau of Maternal and Child Health be asked to assist the Woman's Auxiliary in providing speakers to take part in rural health information programs on Pre-School Child Health; that a committee of the Academy of Pediatrics be asked to prepare a model talk for this program; and that a list of speakers be provided the Woman's Auxiliary, comprising doctors who will be willing to take part in this program.

(2) That endorsement be given the safety campaign of the Safety Council of the Metropolitan Life Insurance Company and that the State Society cooperate in any way that seems fit.

(3) That cooperation with and support of the program of post-graduate pediatric education of general practitioners, as inaugurated by the Academy of Pediatrics, be approved.

C. The Advisory Committee on Tropical Diseases, which has limited its activity in the past to abstracting original articles on this subject, asked permission of the Public Health and Welfare Committees to take on a second activity, namely, to act as a Bureau of Information for the members on tropical diseases.

The Welfare Committee recommended that the Advisory Committee on Tropical Diseases be granted permission to act as a Bureau of Information to physicians of the state by writing personal information on problems in this field.

Public Relations Committee

A. The committee reported on major activities upon which they have concentrated during the summer months and presented the following recommendations, which were approved by the Welfare Committee:

(1) That an annual conference of county presidents and secretaries be held each fall to review all major programs and to impress upon them the importance of better coordination and the provision of more regular information to the State Society as to their progress in developing our major projects.

(2) That the Public Relations Committee hold two conferences, one with editors of daily papers, wire services and selected weeklies; a second with news editors or radio stations; that these conferences take the form of dinner meetings, the expenses to be met from the budget appropriated to the Public Relations Committee for such purposes; that the conferences attempt to draft a code of cooperation comparable to that developed in Colorado; that this draft, if agreed upon at the first conference, be submitted to the Welfare Committee and Trustees for eventual approval on the part of the Society.

(3) That the Chairman of the Public Relations Committee be authorized to attend the A.M.A. Medical Public Relations Conference in St. Louis, November 27, with his expenses to be paid by the Society.

B. As a follow-up of a policy already adopted by the Board of Trustees last November, the committee feels that it is most essential that the bond issue be approved by the people and believes that the Medical Society should lend its active support to the many other proponents of the bond issue through a resolution and by whatever publicity can be obtained for it. (The proposed resolution was approved by the Welfare Committee.)

Medical Practice Committee

A. A communication from the New Jersey Obstetrical and Gynecological Society requested that a study be made of approved residency and intern training in obstetrics and gynecology in the general hospitals in the state. The committee feels there is merit in this request and made the following recommendation, which was approved by the Welfare Committee:

That the Medical Education Committee study the problem of obtaining a sufficient number of properly qualified residents and interns in obstetrics and gynecology in the hospitals of New Jersey, and make a survey of general hospitals to determine which have, (1) obstetrical services, (2) gynecological services, (3) sufficient patients and facilities to qualify for an approved residency in obstetrics and gynecology; the committee to report back to the Trustees with recommendations.

B. The Benjamin Franklin Clinic of the Pennsylvania Hospital in Philadelphia is organized for the medical study of private patients referred by private practitioners (family physicians) to whom it offers diagnostic and consultative aid with all necessary laboratory and x-ray tests and examinations at an all-inclusive fee of $100. The committee questioned whether such clinics constitute hospitals practicing medicine.

The Welfare Committee recommended that the Secretary of the State Society write Dr. Elmer Hess, President of the Pennsylvania State Medical Society, and Dr. A. Reynolds Crane, Secretary of the Benjamin Franklin Clinic, for their opinion as to whether the Benjamin Franklin Clinic and similar clinics in Philadelphia constitute the invasion of the private practice of medicine by hospitals.

C. The Advisory Committee on Laboratory Medicine reported that local and individual attempts to gain the cooperation of undertakers to discuss the matter of autopsies has been only partially successful.

The Welfare Committee recommended that an appropriate committee be appointed from The Medical Society of New Jersey to meet with a committee from the State Society of Funeral Directors to work out the problem of autopsies on a state level, so that the hospitals of this state may increase their educational facilities to interns and staff members.

D. The same committee reported that the quality of work done in lay-directed clinical laboratories is frequently inferior to that performed in laboratories directed by pathologists who are graduates in medicine. Some are allegedly offering rebates to physicians, examining blood of diabetics and advising them on insulin dosage, and are securing a "corner" on the premarital blood tests. The committee

feels that the great number of lay-directed laboratories discourages young men who might otherwise enter the specialty of laboratory medicine, and diverts income from hospital and private-physician directed laboratories which income would make it possible to extend and improve the practice of clinical pathology.

The Welfare Committee recommended that a committee be appointed to study proper regulations of lay-operated clinical laboratories.

E. The committee also presented the matter of premarital blood testing and examination, the procedures of which, it feels, are not understood by many physicians nor do they understand what is expected of them in regard to the physical examination. Some refuse to examine the applicants or sign the medical certificate sending them back to the laboratory where the serologic examinations have been made.

The Welfare Committee recommended that the matter of premarital blood tests and examinations be brought to the attention of the membership concerning their legal responsibility for these tests and examinations; the act providing for premarital tests to be explained through the medium of the State JOURNAL or whatever other means may be recommended, such article to be prepared by the Committee on Laboratory Medicine.

BOARD OF TRUSTEES

September 26, 1948

The Board of Trustees held a regular meeting in Trenton on September 26, 1948. An abstract of the actions follows:

1. Minutes of the June 6, 1948, meeting were approved as distributed.

2. The recommendation of the Medical Education Committee, that the Society stimulate action for the appointment of the fact finding commission to study the question of a New Jersey Medical School, as requested in the resolution of the House of Delegates, was approved.

3. In accordance with the amended by-laws of the A.M.A., the Trustees elected Dr. David B. Allman as delegate to sit at the 1948 interim session of the A.M.A. in St. Louis; and elected Dr. William E. Bray as his alternate.

4. The Trustees authorized the continuance of remission and credit of dues to members discharged from military service.

5. The following recommendations of the Special Committee to study the program and sessions of the annual meeting were approved:

a. Communications be sent to all delegates impressing upon them the responsibility of their elected office; and to the county presidents urging the election of delegates who will attend the meetings.

b. Schedule for the 1949 Annual Meeting:

Monday, April 25, 1949:
Noon—Exhibits open.
2:00 p. m.—6 Scientific Sections.
8:30 p. m.—Nominating Committee.

Tuesday, April 26, 1949:
10:00 a. m.—House of Delegates (first session).
2:00 p. m.—6 Scientific Sections.
8:30 p. m.—Reference Committees.

Wednesday, April 27, 1949:
10:00 a. m.—General Session.
12:00 Noon—House of Delegates (election).
2:00 p. m.—House of Delegates (final session).
6:30 p. m.—Cocktail party.
7:30 p. m.—Banquet.

Thursday, April 28, 1949:
10:00 a. m.—6 Scientific Section Meetings.
12:00 Noon—Exhibits close.

6. The House Committee was authorized to purchase a new car for the use of the executive staff, the purchase price not to exceed $2,500.

7. The following recommendations of the Special Committee on the General Practitioner's Award were approved:

a. Dr. Jacob S. Wolfe, Bloomfield, be named as New Jersey's candidate for the A.M.A. General Practitioner's Award for 1948.

b. Communications be sent to county societies requesting early nominations for the New Jersey award in 1949.

c. An annual expenditure not to exceed $50.00 for an engraved key to be given the recipient of the award.

8. The President was authorized to name a committee of three from the society to act as a medical advisory committee to the Medical Director of the Unemployment Compensation Commission in the administration of the Cash Sickness Benefits Law.

9. The program of the New Jersey Diabetes Asociation was endorsed in principle.

10. The Board went on record as opposed to having commercial exhibits during Public Health Week.

11. The Trustees approved the recommendations of the Welfare Committee (page 506) with the exception of the recommendation on the Benjamin Franklin Clinic and the recommendation on the study of regulations of lay-operated clinical laboratories; these three matters were disapproved.

12. The progress report of the Auxiliary on the establishment of fourteen County School Health Councils was approved, and the Trustees expressed their appreciation to the Auxiliary for its efforts in implementing this program for the Society.

The Trustees approved a recommendation that the County Societies, in which counties school health councils exist, be informed of their responsibility in watching over these councils and seeing that they are conducted in a manner that will be an honor to the county and state societies.

13. The following resolution, to be placed upon the records and to be transmitted to the family of Dr. George W. Fithian, recently deceased, was approved:

After almost fifty years of service to his community, our friend and colleague, George W. Fithian, has passed to his final reward.

As a citizen, as a physician and as a friend, he so conducted his activities that he has left a memory in the hearts of his community and of our Society, of which we, his associates, are justly proud. As a physician and surgeon, he commanded the respect of his colleagues. As a citizen, he was most generous in the expenditure of his time and talents to his community and to his government. As a friend, he was unswerving in his loyalty. In his passing his community has lost a faithful servant and we, "The Medical Society of New Jersey", a valued member and wise counsellor.

As we join with his family in sharing their sorrow at our mutual loss we express to them the fervent hope that the position of respect which he attained in his community and the high regard that his professional conduct won for him among the members of his profession will be a source of consolation to them in their loss.

14. Dr. William C. Wilentz, Perth Amboy, was elected to fill the vacancy on the Board of Trustees from the Third District, caused by the death of Dr. Fithian, until the next annual meeting.

15. Dr. Patrick H. Corrigan, Dr. James F. Norton and Dr. Joseph F. Londrigan were nominated, in the order named, as candidates for appointment by the Governor to the State Board of Medical Examiners.

16. Dr. Scott was named as the Society's representative to meetings of the American Public Health Association.

17. The Trustees approved the Statement on Blue Cross-Blue Shield Association and Blue Cross-Blue Shield Health Service, Inc., prepared by Dr. Scott in the name of the Society and the Medical-Surgical Plan, which statement will be read before the A.M.A. Council on Medical Service in Chicago on September 30 and before the Special Committee of the New York Society on October 14.

EXPANDED GRADUATE PROGRAM

Under the joint auspices of The Medical Society of New Jersey and Seton Hall College, graduate courses are available for periods of from ten to thirty weeks, in both the fall and spring semesters.

Courses offered this fall include: Pathology of internal medicine; surgical pathology; surgical anatomy; cardiology, electro-cardiography and fluoroscopy of the heart; biochemistry; diagnostic roentgenology; peripheral vascular disorders and vascular surgery; therapeutics and pharmacology and gynecologic pathology.

Courses planned for the spring semester include proctology, pediatrics, anesthesia, physiology, otolaryngology and gynecology.

The course on vascular diseases is the first of its kind ever offered in New Jersey. It will be given by Dr. Walter Redisch, Chief of the Professional Services Section of the Newark Regional Office of the Veterans Administration. The surgical aspect of vascular disease will be presented by Dr. Gerald H. Pratt of Post Graduate Hospital, New York. Other members of the faculty include: Dr. Harry Gold, professor of pharmacology at Cornell Medical School and a cardiologist; Dr. Ernest Lampe, Cornell anatomist; Dr. M. J. Fein of Post Graduate Hospital, New York; Dr. Abraham Cantarow, professor of biochemistry at Jefferson Medical College, Philadelphia; Dr. Charles Gottlieb, professor of radiology at New York University Medical School, and Dr. Irving Graef, professor of medicine at New York University.

For further information, write to Dr. Gerald Cetrulo, 234 Mt. Prospect Avenue, Newark 4, N. J.

NEW JERSEY ACADEMY OF GENERAL PRACTICE

General practitioners and family doctors of New Jersey now have an organization that they can call home. At long last, there has been established a New Jersey Academy of General Practice. This is the state chapter of the nationwide American Academy of General Practice, and it came into being on August 24, 1948.

To be eligible for membership, a physician must have been in general practice for three years and must be a member of The Medical Society of New Jersey.

Objectives of the Academy are: to assist physicians in preparing for, and establishing themselves in general practice; to preserve the right of the G.P. to engage in medical and surgical procedures for which he is qualified; to help provide graduate courses for general practitioners; to establish general practice staffs at hospitals; and to maintain top-notch standards of general practice.

Membership blanks may be obtained from any of the officers. These are:

President: Samuel Kaman, 1616 Pacific Avenue, Atlantic City, N. J.

Vice-President: Aaron Horland, 87 Chancellor Avenue, Newark 8, N. J.

Treasurer: Sidney Becker, 140 Maple Place, Keyport, N. J.

Secretary: Edwin Rosner, 814 Haddon Avenue, Collingswood, N. J.

STATE LEGISLATIVE ACTIVITIES

Under the original provisions of S-23, the professional licensing boards would have been placed within the Department of State. Because of strenuous objections to this by the professions, and as a result of a conference by representatives of the various professions with Governor Driscoll, this idea was abandoned. While it is the consensus of representatives of the professions that the best solution of the problem would have been the creation of a Department of Professional Boards, it finally became apparent that this was impossible of attainment and that the boards would be set up as a division within one of the existing departments. It was the opinion of the executive committee of the Council of Professions that the most logical and desirable department to place the boards was the Department of Law and Public Safety. The Governor and the Joint Legislative Committee on State Reorganization accepted this recommendation.

It is believed that, under the terms of S-27 (setting up a Division of Professional Boards within the Department of Law and Public Safety) the essential powers, functions and duties of the boards have been preserved. While it will be necessary for the various professional boards to procure, as it will be for all other departments, an appropriation from the state to carry on their work, earmarking of the funds for 1949 as provided in the bill will indicate to subsequent legislatures that this was the method to be followed in providing future appropriations.

The Optometry Bill, S-171, which passed both houses after deletion of all provisions that were objectionable to our Legislative Committee, was vetoed by Governor Driscoll presumably because of representations made by the press of the state. A new bill, S-394, apparently worded so as to remove the objections of the newspaper publishers, was introduced. This passed the Senate but on objections by the press was further amended in the Assembly, removing all provisions relating to advertising with the exception of the prohibition against false advertising. Presumably the Governor will sign this, but in our opinion, this measure now is merely a shell of the original proposals.

The Chiropody Bill, A-517, was introduced May 12. A study disclosed no objections to the bill as a whole, but a provision which would have made the chiropodist member of the State Board of Medical Examiners sole judge of what constituted unprofessional conduct as a possible cause for revocation or suspension of license was stricken from the bill, at our insistence. Also, an amendment suggested by us which makes it necessary for chiropodists using the title "Doctor" or its abbreviation to qualify the term by addition of the words "Chiropodist" or "Surgeon Chiropodist" was included. The measure in this shape has passed the legislature and is awaiting action by the Governor.

Assembly Concurrent Resolution 13, which passed the Assembly May 12, creating a committee to investigate the licensing and regulating of chiropractic, was amended in the Senate, during the adjourned session to provide for appointment of a committee of five by the Governor. The bill was repassed in the Assembly with the Senate amendments.

A so-called "Milk-Control Bill", A-567, was introduced August 25. The original proposal

would have divested the Department of Health of all sanitary control over the production and sale of milk. As a result of joint action of our Legislative Committee, the Health Officers' Association and the New Jersey Health and Sanitary Association, the bill was amended. But even after amendment it was in such shape as to elicit from Health Commissioner Bergsma, according to press accounts, the statement that the bill is "ridiculous, silly and quite illogical". The measure was unable to command sufficient support to warrant bringing it to vote.

Under the provisions of S-147, the Cash-Sickness Benefits Bill, which has been enacted into law, an advisory council of twelve was to be created, two of whom would be physicians. Such appointments are to be confirmed by the Senate. Names of the advisory council were not submitted to the Senate prior to adjournment, so presumably the Governor will make these as *ad interim* appointments, subject to confirmation by the Senate next year.

An amendment to the Cash-Sickness Benefits Law, (S-147), which became effective June 1, 1948, passed both Houses between August 20 and August 30. This bill is now, presumably, before the Acting Governor. The amendment reads as follows:

> Notwithstanding any other provision of the Act of which this is a supplement, benefits shall not be denied to an otherwise eligible individual for any period during which such person is under the care of a licensed dentist, who, when requested by the Commission shall certify within the scope of his practice, the disability of the claimant, the probable duration thereof and the medical facts within his knowledge.

The original law did not authorize certification of disability of persons under the care of dentists. This amendment validates such certification within the scope of their practice. The state of California after several months of operation amended its law to provide for such certification by dentists.

A "Beauty Culture Bill", A-520, among other proposals would have designated beauty culture as a "profession". This bill (which was introduced May 14) remained in the Public Health Committee.

FREDERIC J. QUIGLEY, M.D.,
Executive Secretary,
Committee on Legislation.

ALLERGY IN GENERAL PRACTICE

All New Jersey physicians will be interested in a practical down-to-earth discussion of allergic problems in general practice scheduled for 9 p. m. on Thursday, October 28. The speaker, Dr. Robert A. Cooke, is director of the Allergy Department of Roosevelt Hospital. The meeting will be held at the Academy of Medicine, 91 Lincoln Park, Newark 5, and will be under the joint auspices of the New Jersey Allergy Society and the Section on Medicine and Pediatrics of the Academy.

OBITUARIES

DR. WILLIAM M. ANDERSON

Dr. William M. Anderson of Haddonfield died on July 24 in Cooper Hospital, following a heart attack.

Dr. Anderson was born in Calais, Maine, in 1881. He completed a two year course at Norwich Military College in Vermont before entering medical school. He graduated from Boston University in 1905 and began his practice in Haddonfield in 1907. In his early years of practice he was on the staff of the West Jersey Hospital and later became affiliated with Cooper Hospital.

DR. OTTO LOWITS

Dr. Otto Lowits of Newark, died suddenly at his home on September 1, at the age of 62.

Dr. Lowits attended Cornell University and was graduated from Long Island Medical College in 1908. He served his internship at Monmouth Memorial Hospital, Long Branch. During World War II he served as an examining physician with Selective Service. He was affiliated with Beth Israel Hospital and the Newark Department of Health.

DR. ROY G. PERHAM

An active Hasbrouck Heights medical practice of more than 35 years ended on August 6 with the death of Dr. Roy G. Perham.

Dr. Perham was born in Rutherford in 1887 and was graduated from Syracuse University College of Medicine in 1912. He was well known in South Bergen territory where he gave much time to local projects. He was health officer for 34 years, during which time he also served as school physician. He helped draft the original health code for Hasbrouck Heights. During the war he was medical examiner for Selective Service.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

FORTIFICATION OF MILK

New requests for approval by public health departments of fortified milk have been made by members of the industry. In considering this question, the Food and Nutrition Board of the National Research Council has restated its position with regard to addition of vitamins to milk. Their memorandum follows:

The Food and Nutrition Board has reviewed its previous actions concerning fortification of milk and reaffirms its decisions. To avoid possible misinterpretation of these decisions the following statements are intended to clarify the Board's position.

According to the decision of December 2, 1944, the Food and Nutrition Board does *not* favor fortification of the general milk supply with minerals or vitamins other than vitamin D. The Board favors fortification of milk with vitamin D to the level of 400 U.S.P. units to the quart when the milk is used as a source of this vitamin. The Board favors fulfillment of the nutritional needs of the people by the use of ordinary foods so far as practicable. To that end it encourages education in proper choice of foods, improvement of food production, manufacture and preparation so as to increase and retain more fully the essential nutrients naturally present, and improvement in distribution so that diets adequate for health may be available to all persons.

According to the decision of July 1947, fortification of milk with vitamin A is not needed because in the United States diets adequate in vitamin A are available and fortification of milk with vitamin A is deemed unnecessary as a general public health measure.

The preceding decisions were not intended to hinder appropriate study and development of nutritionally useful new products. The Board realizes that development in technology and nutrition is rapid and does not favor restrictions which unduly handicap such progress. It did not assume and does not now intend that its decisions cited above should be interpreted as grounds for prohibiting investigation and market trials with milk modified by the addition of appropriate ingredients in reasonable amounts.

Modified forms of milk generally involve advance in price, at least during the early period of development. The Board emphasizes that wider and more uniform consumption of milk is highly desirable from the standpoint of public health and it is particularly concerned with making available the best quality of milk at low cost.

PARESIS, TABES DORSALIS, AND PRIMARY OPTIC ATROPHY

A statement was issued December 1, 1947, by the Syphilis Study Section of the National Institute of Health, to the Council on Pharmacy and Chemistry of the American Medical Association, recommending that 10 to 20 million units of penicillin be administered over a 10 to 20 day period, accompanied by fever therapy (unless contraindicated) in cases of paresis, tabes dorsalis and primary optic atrophy.

At present, opinion among syphilologists favors the use of penicillin alone even in cases of symptomatic neurosyphilis. Such authorities as John H. Stokes, Evan Thomas, and Bernhard Dattmer have recommended penicillin alone.

Arrangements for fever therapy for such cases at Medical Center, Jersey City, proved to be impractical. Patients with tabes dorsalis and primary optic atrophy will now be accepted under the state plan for treatment with penicillin alone and hospitalization will be provided for a 10 to 20 day period, as beds are available. Mentally disturbed patients should be sent to mental institutions; other paretics may be hospitalized for the same treatment as outlined above for tabetics.

CONGENITAL SYPHILIS

Children with congenital syphilis should receive a higher dosage of penicillin, (in proportion to body weight) than adults. Under the state plan, it is recommended that the smallest two-hourly dosage should be 10,000 units of aqueous penicillin. Infants over 10 pounds in weight should receive, every two hours, the dosage indicated by multiplying 1000 units by the pounds of body weight. Patients over 50 pounds should receive the usual adult dosage of 50,000 units every two hours. A ten day period of hospitalization is provided, with 120 injections and a total dosage of 1.2 to 6 million units of aqueous penicillin.

COUNTY SOCIETY REPORTS

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The Burlington County Medical Society held its first meeting of the 1948-49 season on September 9, 1948, at the Riverton Country Club. The meeting was called to order by the president, DR. PAUL R. SPARKS.

Dr. S. Emlen Stokes introduced the guest speaker of the evening, DR. AIMS C. MCGUINNESS, Director of the Children's Hospital of Philadelphia and Assistant Professor of Pediatrics at the Medical School of the University of Pennsylvania. The subject of his talk was the "Review of Diagnosis and Treatment of Infectious Diseases in Children".

Dr. Emlen P. Darlington of New Lisbon, having retired from active practice after twenty years of service, was granted an emeritus membership in the Burlington County Medical Society.

Dr. William E. Bray, chairman of the Public Relations Committee of the State Medical Society gave a brief outline of the committee's program for this year.

The chairman of the County Executive Commitee, Dr. E. Warren Rodman, proposed several topics for discussion. First, it is the duty of the County Society to see that the articles released by the State Society are published in all the county's newspapers. Second, each community should work out a program among its physicians so that there will always be at least one doctor available for twenty-four hour service. Lastly, it was requested a budget report be presented at each January meeting.

DR. JOHN T. BAUER of Moorestown transferred his membership from the Philadelphia County Medical Society to the Burlington County Medical Society. He is the pathologist at the Burlington County Hospital.

HUNTERDON COUNTY

H. A. Davidson, M.D., Reporter

Neither rain nor storm nor thunderbolts kept the members of the *Hunterdon County Medical Society* from the annual picnic and social meeting on the afternoon of Sunday, August 22. The event was held in rural Flemington on the lawn and terrace of this reporter's home; and when a persistent rainfall dampened the charcoal embers in the outdoor grill, the party briefly moved indoors and found that hamburgers cooked in an electric oven were almost as tasty as those made *al fresco*. The Woman's Auxiliary to the Hunterdon County Medical Society, itself a youthful and recently organized unit, sponsored the picnic and did all the buying, cooking, and serving, and also did about half of the eating. There were ice cream and apple pies, hamburgers and potato chips, munched pleasantly on the lawn in the clean after-the-storm atmosphere, and in a post-card setting furnished by glow of sunset against the hills of Hunterdon. A few timid souls, frightened by the rain, stayed away. They missed the kind of meeting which serves to point up the fact that a medical society is not only an educational organization; it is—or could be—a communion of fellowship, too.

SALEM COUNTY

A. S. Mason, Sr., M.D., Reporter

With DR. D. G. NEANDER, the president in the chair, the *Salem County Medical Society* held its regular monthly meeting at the duPont Country Club, Carney's Point, September 17, 1948.

Dr. F. L. Perry introduced the guest speaker, DR. P. D. GELBERT, roentgenologist of Camden, whose subject was *X-ray Diagnosis*. Dr. Gelbert presented and illustrated with slides several cases, the most interesting of which were *carcinoma of the esophagus, carcinoma of the bronchus* and *thoracic heart*.

In the business session which followed, the following were elected Delegates to the State Medical Society: DR. H. F. SUTER, three years; DR. F. L. PERRY, two years; DR. C. S. DAVISON, one year. Alternates are: DR. M. CHESLER, three years; DR. C. B. MACKES, two years; DR. W. S. DAVISON, one year. Dr. Suter was named Nominating Delegate and Dr. C. S. Davison, alternate.

SUPPLEMENTARY LIST No. 5
TO THE
1948 OFFICIAL LIST OF MEMBERS

Arndt, Frank P., 7500 Bergenline av., No. Bergen(9)
Booken, Gerald, 1 Johnson av., Newark (7)
Gleason, Thomas P., 82 W. Fifth st., Bayonne (9)
Gowen, Mortimer, 1330 Oak Tree rd., Iselin (12)
Gullord, Edward G., 21 Trinity pl., Montclair (7)
Harrington, Walter L., 104 S. Munn av., E.Orange(7)
Ingling, Harry W., 51 W. Main st., Freehold (13)
Maxwell, Carl A., Veterans Hosp., Clevel'd, Ohio(21)
Parkes, Morey, Gallanger General Hospital, Washington, D. C. (7)
Reilly, John T., 18 DeHart st., Morristown (14)
Rizzo, Ettore G., 352 Van Houten st., Paterson (16)
Rush, Martin R., 326 Broad st., Red Bank (13)
Schulman, Jesse, 518 Second st., Belvidere (21)
Sheffield, Doreen, Oxford (21)
Snagg, William T., 719 Cooper st., Camden (4)

ASSOCIATES

Grubin, Charles J., 1410 Maple av., Hillside (7)
Padovano, Joseph, 517 Roseville av., Newark (7)

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

MRS. ROBERT B. WALKER, President

Last month it was my privilege to mail to each member a copy of the first issue of the Bulletin of the Woman's Auxiliary to The Medical Society of New Jersey. I have long felt the need of an auxiliary publication. The Bulletin is designed to stimulate interest in the auxiliary and to provide information for your guidance. It is important that we share with each other the knowledge of things well done and of worthy causes sponsored and promoted.

It is my hope that the spirit of good will contained among its pages shall be an animating force so that it may grow until it has become an integral part of the organization.

The Medical Society has been most generous in providing us with space in the medical JOURNAL. I feel that there were times when the Editor needed the space alloted to us for the more important work of the Medical Society. We talk much of helping the profession; this is only one small bit of aid, but small things are often most important. This year we shall continue to send the county reports to the JOURNAL. Please read all of the JOURNAL each month. It will keep you informed and a well informed member is alert to her obligations as a member of the Auxiliary.

AUXILIARY REPORT

Atlantic County

Mrs. E. H. Nickman,
Chairman, Press and Publicity

MRS. ALLMAN HONORED AT TEA

The Stratosphere Room of the Hotel Traymore was the setting for a cheerful gathering on Thursday, July 7, as the wives of medical men from Atlantic County offered their congratulations and best wishes to Mrs. David B. Allman, President-elect of the Woman's Auxiliary to the American Medical Association. It is the first time that a member from New Jersey has been elected to head the National Auxiliary. Because of this honor, members of the Executive Board to the State Auxiliary were also present.

Mrs. Harry Subin, President of the Auxiliary of the Atlantic County Medical Society, presided very graciously at the tea.

Mrs. Allman was most becomingly dressed in a grey sheer with lace insertions, topped by a grey milan hat. Mrs. Subin selected a black ensemble and large black picture hat.

Those present were Mesdames Chester Ulmer, Thomas McGlade, W. G. Talmage, John T. Leslie, Samuel Jessurun, William Dodd, Thomas McConaghy, J. H. Hornberger, Ellis Allar, Barney Barab, Harold Bayer, Ily Beir, Robert Bradley, Leonard Ellenbogen, Edward Dyer, Myrtile Frank, Perry Frank, Edward Guion, Samuel Halpern, Charles Hyman, Samuel Kaman, Herman Kline, I. E. Leonard, Jr., Manuel Mally, James Mason, A. G. Merendino, Cesare A. Milano, Mathew Molitch, T. J. McGahn, E. H. Nickman, John Perez, Stella Poland, Thomas Petinga, Daniel Reyner. Mrs. Alan Rieck was accompanied by her daughter, Jane. Others attending were Mesdames Louis Rosenberg, Samuel Salasin, D. Ward Scanlan, Irving Shavelson, I. Stalberg, G. R. Stamps, Rolfe Westney, Lawrence Wilson, P. C. Martucci and Robert Sinderbrand.

Bergen County

Mrs. Winton Johnson, Chairman of Publicity

The *Woman's Auxiliary to the Bergen County Medical Society,* which was re-organized last March and now has a paid-up membership of fifty, opened its fall season with a membership tea at the home of its president, Mrs. Floyd Keir, Englewood, on September 14.

Mrs. Walter Jordan, Englewood, president-elect of the Auxiliary, is chairman of Health Week which will be observed in November, and will cooperate with Dr. Edward E. Wolfe of Teaneck, chairman for the Medical Society. Mrs. Edward Sexton, Teaneck, first vice-president, is chairman of Public Relations. Mrs. Thomas Garrett, Hackensack, second vice-president, is chairman of Membership. Mrs. Louis DeLuca of Ridgewood, is treasurer of the Auxiliary, and Mrs. Frederick Muller of Carlstadt, is recording secretary.

Mrs. Ralph Gilady of Hackensack, has been appointed chairman of Safety. A comprehensive program on safety, in cooperation with the New Jersey Safety Council, is being planned by the State Auxiliary. Mrs. Mincke is Program chairman, assisted by Mrs. Salva. The Budget committee is headed by Mrs. G. G. Steneck of Bogota. Mrs. Luke Mulligan of Leonia is in charge of Legislation; Mrs. E. Scheer of Teaneck, Constitution and By-Laws; and Mrs. R. Bryan Hillsman of Teaneck, is chairman of Hygeia Magazine distribution. Publicity chairman is Mrs. Winton Johnson of Hackensack.

Directors of the Auxiliary include: Mrs. J. L. York of New Milford, Mrs. Ralph Gilady of Hackensack, Mrs. E. J. Salva of Palisades Park, Mrs. Peter Mincke of Saddle River, Mrs. Philip Busicco of Englewood, and Mrs. Kenneth M. Delafrange of Westwood.

BOOK REVIEWS

Synopsis of Obstetrics. By H. C. Litzenberg, M.D., 3d ed. Pp. 399. St. Louis. C. V. Mosby Co., 1947. ($5.50).

Obstetrics, both normal and abnormal, is covered completely yet succinctly in this small volume. Beginning with a discussion of the anatomy of the reproductive organs, the book carries on the chapters on menstruation, the physiology of pregnancy, mechanism of labor, pathology of labor, and so on, ending with a chapter on obstetric surgery.

The chapters on physiology of pregnancy and physiology of labor are especially interesting, the latter in particular making its points concisely and clearly. The pages devoted to control of pain in labor are worthy of study. The various barbiturates are discussed, and potential dangers are mentioned. The pros and cons of caudal anaesthesia are mentioned. The author gives the impression of being in doubt as to its complete safety.

This synopsis of obstetrics is well worth having and reading.

Philip Grossblatt, M.D.

Diabetes Mellitus in General Practice. By Arthur R. Colwell, M.D. 336 pp. Chicago. The Year Book Publishers, Inc. 1947. $5.25.

Dr. Colwell has written a readable useful text for the general practitioner and student. His approach is based on his own experience and unencumbered by masses of statistical data. While some of his methods deviate somewhat from those described in the standard textbooks, they are scientifically sound and will no doubt yield just as good results.

The author devotes a section to a discussion of the "objectives of treatment" which he fervently argues for strict chemical control of the patient. However his position is weakened by the statement "a large group of complications, predominantly vascular, are not so favorably influenced by treatment of the accompanying diabetes". In any event there should be general agreement with the author's opinion that the burden of proof as to the harmlessness of lax chemical control rests with the advocates of such control.

A most interesting item is the chart obtained by plotting insulin requirement against onset and duration of diabetes to a common source of origin. The author comes to the conclusion that diabetes is inherent, that it begins at birth, and that before it is recognized in clinical practice it progresses through a stage, the magnitude of which is fully as great as that of the known diabetes which follows recognition. I cannot criticize the mathematical methods by which the author comes to these conclusions, however, the conclusions themselves are most arresting.

Louis Grunt, M.D.

Mental Health in Modern Society. By Thomas Rennie M.D., and Luther Woodward, Ph.D. 424 Pp. Commonwealth Fund, New York, 1948. $4.00.

Psychiatry is the one specialty in medicine with the greatest area of contact with outside disciplines. While other specialists may seek to preserve health in their fields without much intimate contact with nonmedical personnel, this would be a hopeless task in the maintenance of mental health. *Mental Health in Modern Society* seeks to weave together the diverse disciplines which make contributions to mental hygiene, to interpret one to the other and to chart the pathway common to all of them.

There are chapters on the contributions of social workers, psychologists, general medical practitioners, the Church, industry, and education. The book is thus hard to classify. It is not a text in psychiatry, nor a summary of sociology. It is comparable, in the "physical disease" field to a book on sanitary engineering, which would draw from the knowledge of engineers, health officers, physicians, bacteriologists, and even plumbers, seeking not to delimit the contributions of each but rather to coordinate them. So here, in mental health, the book lays down the essentials of sound mental hygiene, underlines the impossibility of doing the job in a social vacuum, describes a little of the content and method of each contributor. For the general medical practitioner it provides a thought-provoking thesis, a challenge, and a vision of untapped potentialities. To the psychiatrist it furnishes a well rounded account of professions tangential to his own—and incidentally, a mine of ideas for public addresses both to the laity and to the general medical profession.

Henry A. Davidson, M.D.

A History of the American Medical Association, 1847 to 1947. By Morris Fishbein, M.D., Pp. 1205. W. B. Saunders Company; Philadelphia and London, 1947. $10.00.

The major portion of this volume deals with the history and growth of the American Medical Association through the past century. A fascinating section is devoted to the libel suits of the Association and touches upon the careers of Harry M. Hoxie of the "Hoxie cancer cure", John R. Brinkley of the famous goat gland operation, Norman Baker and many others.

A separate section is devoted to the biographies of the Presidents of the Association, and is written by Walter L. Bierring. The concluding quarter of the book deals with the Councils and Bureaus and the various publications of the American Medical Association.

I. J. Bernstein, M.D.

Medical Hypnosis. Lewis R. Wolberg, M.D. Two volumes, 962 pp. Grune and Stratton, New York, 1948.

"How to do it" books are rare in psychiatry. Wolberg's double volume monograph therefore is doubly welcome. The first volume outlines the technic of hypnotherapy in neat 1, 2, 3, fashion. Recorded transcripts of hypnotic sessions are reproduced in verbatim detail, with accompaning explanations so that the physician can actually put the procedure to the test. The possible fields of usefulness of hypnosis are objectively reviewed, with adequate attention to the dangers, contra-indications and limitations. Generous excerpts from actual hypnotic sessions are cited to support every suggested use. Wolberg also offers a rich reservoir of detailed case material. On the whole, this is a pair of books which belong in any well rounded personal psychiatric library.

Abraham Leff, M.D.

Synopsis of Neuropsychiatry. By Lowell S. Selling, M.D. 2d ed. Pp. 561. St. Louis, The C. V. Mosby Company, 1947. $6.50.

Perhaps this examiner belongs in that group of reviewers whom the author refers to in his preface as "caustic critics who assume that the day of the synopsis is past and that the synopsis type of book is an anachronism". Certainly, one cannot but be overwhelmed by the magnitude of the task undertaken in compressing the vast material of psychiatry and neurology into 561 small pages.

The writing is telegraphic in style. The material is presented as title, synonym, definition, etiology 1-2-3, pathology, symptomatology 1-2-3, differential diagnosis 1-2-3, medical-legal, prognosis and treatment. All unnecessary words have been deleted and with them have gone considerable material of value. The index reveals that everything from the abducens nerve to zona has been covered in the book. Some of the subjects—such as the psychopathic personality, malingering, and others in which Selling is an acknowledged authority—have been handled in a truly masterful manner. Others leave something to be wished for. "Multiple sclerosis", for instance, does not appear in the index. If the reader is acquainted with the less common name of "disseminated sclerosis", he can find it after he has read the outline. Unless he is already a rather profound student of neurology, he will be thoroughly confused.

The book is an excellent one because of its dictionary-like character for the specialist who cares to review and strike the "highlights" of the various syndromes. The amount of material Dr. Selling has compressed into the book, despite my criticism, is truly remarkable. Nevertheless, it cannot be recommended for the general practitioner or student because its staccato character prevents the reader from obtaining a rounded picture of the syndrome with which he might be dealing and opens the avenues to too many errors. Instead, it is felt that recourse to the standard neurologic and psychiatric tests would give a far smoother, far better rounded, more practical grasp on any subject upon which the physician was seeking assistance.

David J. Flicker, M.D.

Medical Writing: The Technic and the Art. By Morris Fishbein, M.D., with the assistance of Jewel F. Whelan. 2nd Edition. Blakiston, Philadelphia, 1948. 292 pages.

"Increasing organization in the field of medicine, as in every other field of human endeavor, has introduced advancement in the production of contributions to medical literature." With this long-worded and complicated sentence, Dr. Fishbein introduces a book devoted largely to a plea for simplicity in style and brevity in words. The text is divided into 18 chapters covering such subjects as spelling, capitalization, abbreviations, citations, charts, proofreading, and illustrations. It is packed with horrible examples showing the medical author what not to do.

To the physician-writer the most valuable sections of the book are those offering concrete data on spelling variants, approved abbreviations, methods of making illustrations, and similar mechanical aids to good manuscript construction. Particularly useful is a complete alphabetical listing of all medical periodicals cited in *Index Medicus*. Official abbreviations and subscription addresses are given for all these publications, American and foreign.

In general, the style suggestions follow the regulations adopted by the A.M.A. for its own publications. The writer who is aiming at the Journal or other periodicals of the American Medical Association will improve the chances of getting his paper accepted if he conforms to these rules. Of course, other publications have their own style manuals; thus, all A.M.A. periodicals use "technic" rather than "technique" and "intern" rather than "interne". Many scientific publications, however, prefer the longer forms, so that the hopeful author cannot meet the requirements of some of the specialized journals simply by following this book. But if he takes to heart the suggestions about simplicity, word choice, and manuscript construction laid down in this volume, and if he is guided by Dr. Fishbein's advice on illustrations, charts, tables and references, he cannot go wrong in meeting the basic requirements of an acceptable medican manuscript.

Henry A. Davidson, M.D.

Infant Nutrition. P. C. Jeans, M.D., and Williams McKim Marriott, M.D. 4th ed., Pp. 495, St. Louis, C. V. Mosby Company, 1947. $6.50.

The appearance of a fourth edition of this book on infant nutrition testifies to the success with which it has achieved its objective of "summarizing present-day knowledge concerning the nutritional requirements of infants under normal and pathologic conditions and to indicate the effects of failure to meet any or all of these requirements".

The present edition shows numerous changes and additions. The work is intended for and is recommended to both the student and the practitioner.

I. J. Bernstein, M.D.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **October, 1948** **No. 10**

IN the war against tuberculosis the mass X-ray survey may well be considered as a reconnaissance undertaken to discover where the enemy is hidden, so that practicing physicians in the area may attack the disease most effectively. It is upon their efforts, supplemented by services within the community and reinforced by public awareness of the problem, that success or failure in the control of tuberculosis depends.

THE COMMUNITY AS A FORCE IN THE CONTROL OF TUBERCULOSIS

Modern epidemiological methods in the control of communicable diseases make it imperative for workers in the field to know where, when, who, and how many any given disease attacks. The swiftest and most efficient way to the heart of this problem in the field of tuberculosis is through X-ray surveys of large population groups, preferably those which compose large metropolitan areas. These present all manner of social complexity, racial variation, and economic resources.

At the beginning of organized control movements, it was believed that the most effective means of discovering the exact nature of the tuberculosis problem in the United States was through surveys of industrial, occupational and racial groups. However, the knowledge thus secured was at best spotty and was likely to be misleading when the whole population of the country was considered. It was thereupon determined to delve into those vast reservoirs of human beings which are our great cities. Here are all the maladies that are suffered by mankind. Through a prompt discovery of the tuberculosis problem in the larger cities of our country, a reasonably exact knowledge of the extent of the problem could be realized, public action stimulated, and professional forces joined.

City-wide X-ray surveys can be conducted with relative economy of means and money. Concentration of personnel, machinery, and educational devices within densely populous communities provides, in certain respects, quicker and more valuable results than do studies conducted in sparsely settled areas. Previous experience in cities already surveyed indicates that if present facilities are fully utilized, the increased case load of tuberculosis will not present a grave problem to the community. Seventy per cent of all new cases discovered by mass X-ray survey are minimal and do not constitute a grievous public health problem. Most of these cases will be noninfectious; the disease process will be incipient; and the probability of serious progression, with adequate follow-up, will be slight. Such cases can be cared for by private physicians and public clinics, assisted by public health nurses and medical social workers. Sanatorium beds now occupied by noninfectious cases can be given over to far-advanced virulent disease which constitutes a menace to the local population.

Minimal, noninfectious cases are private physicians' cases, not sanatorium cases. The private practitioner can be a major force in the future control of tuberculosis in the communities of our country if he participates in follow-up activities after the survey has been completed. Through his efforts, minimal tuberculosis can be checked and, in individual cases, never become serious. Under the physician's care, needless distress and tragedy can be avoided. As a consequence of his vigilance, the general practitioner can reduce measurably the occurrence of deaths from tuberculosis.

Often communities can afford to enlarge present clinic and hospital facilities when they cannot afford to build new institutions. Recruiting professional personnel is always a serious problem everywhere. However, resolute efforts to procure and then train professional workers will be productive of fruitful results.

An aroused community makes for organized action. An informed community acts collectively as a social weapon against any threat to its existence. A community aware of the problem confronting it and organized for effective action is the principal force in a program to control tuberculosis. Isolated leaders and their followers, no matter how well trained or how profoundly dedicated, have little potency without the strength inherent in the human and economic resources of mobilized communities. By now it must be plain that the fight against tuberculosis is a social and economic movement as well as a disease problem. We now have enough information to be confident that an awakened awareness of the people is the chief tool for triumph.

The Community as a Force in the Control of Tuberculosis, Francis J. Weber, M.D., Editorial, Public Health Reports, September 5, 1947.

SUPPLIED BY

NEW JERSEY TRUDEAU SOCIETY,
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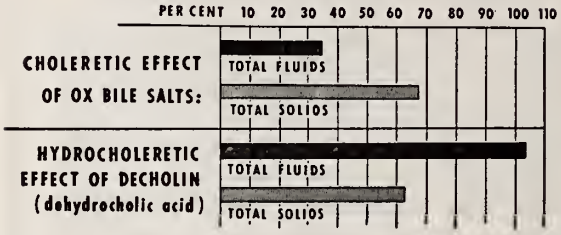
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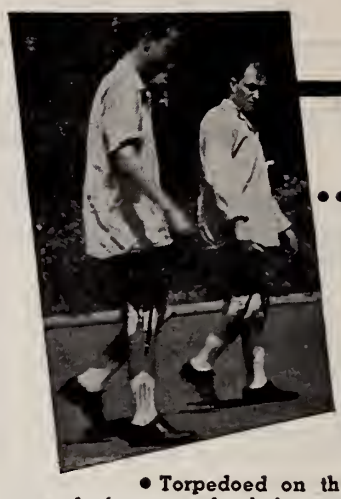
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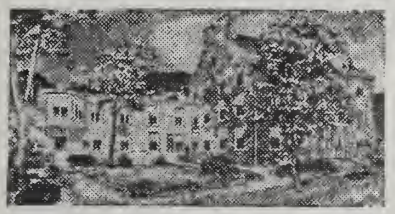
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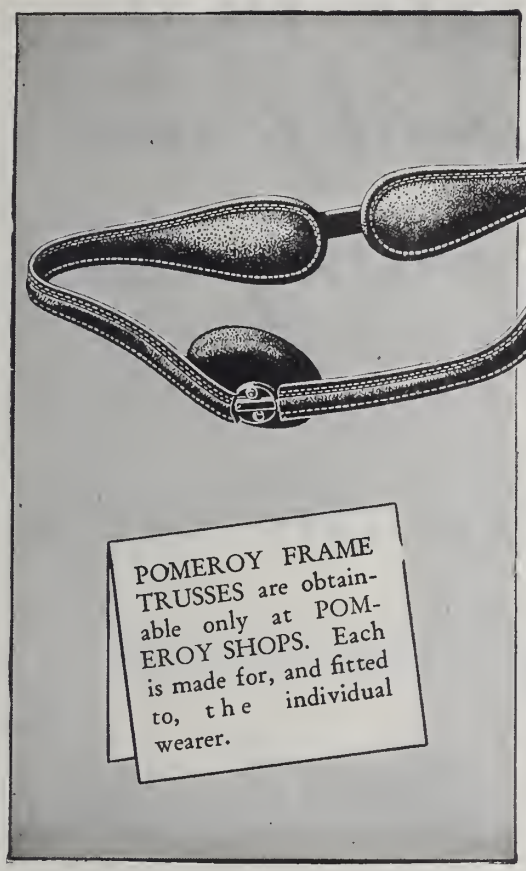
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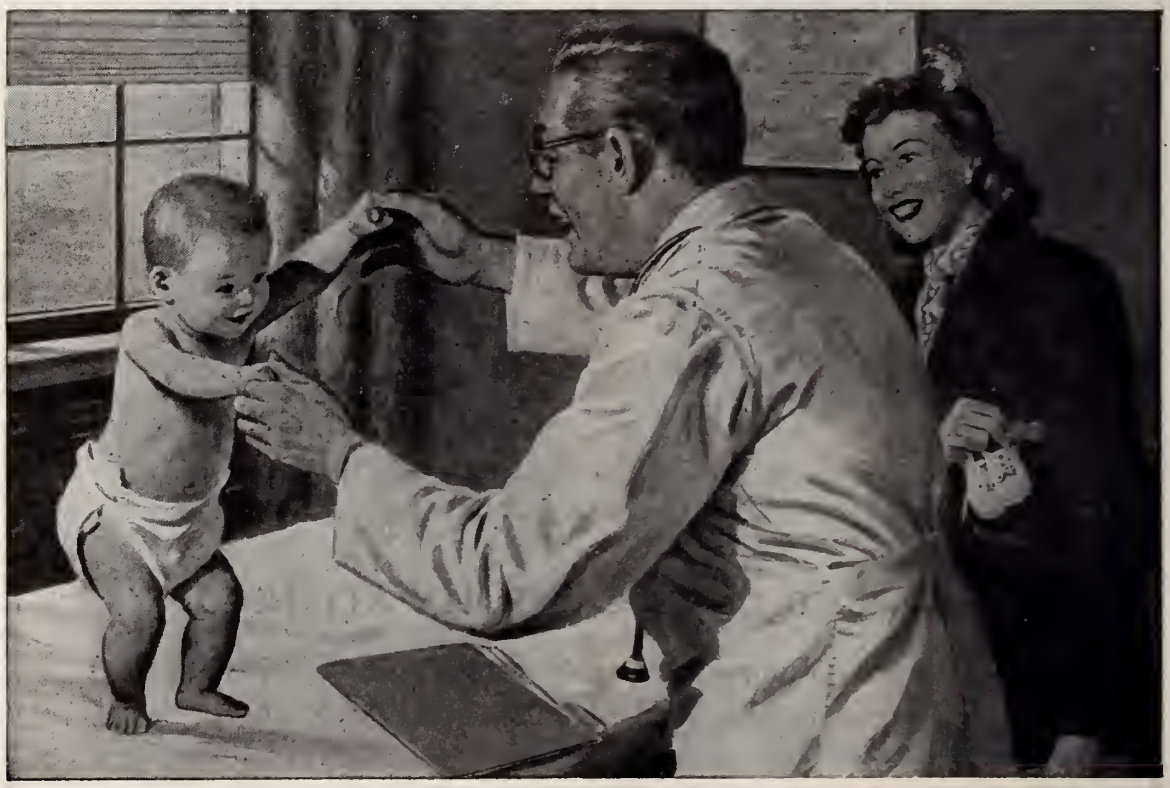
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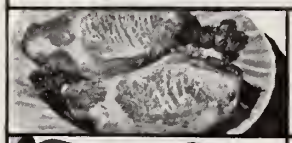
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D21

The Abundant Nutrient Values of MEAT

KIND OF MEAT	COMPLETE PROTEIN	B VITAMINS			FOOD IRON
		THIAMINE (B_1)	RIBOFLAVIN (B_2)	NIACIN	
 PORK	EXCELLENT	EXCELLENT	FAIR	EXCELLENT	EXCELLENT
 BEEF	EXCELLENT	FAIR	EXCELLENT	EXCELLENT	EXCELLENT
 LAMB	EXCELLENT	FAIR	GOOD	EXCELLENT	EXCELLENT
 VEAL	EXCELLENT	GOOD	GOOD	EXCELLENT	EXCELLENT
 VARIETY MEATS (LIVER, HEART, KIDNEY)	EXCELLENT	EXCELLENT	EXCELLENT	EXCELLENT	EXCELLENT
 SAUSAGE (FRANKFURTERS, BOLOGNA)	EXCELLENT	GOOD	GOOD	GOOD	EXCELLENT

ALL VALUES ARE BASED ON COOKED MEATS . . . MEAT ALSO SUPPLIES SIGNIFICANT AMOUNTS OF COPPER AND PHOSPHORUS

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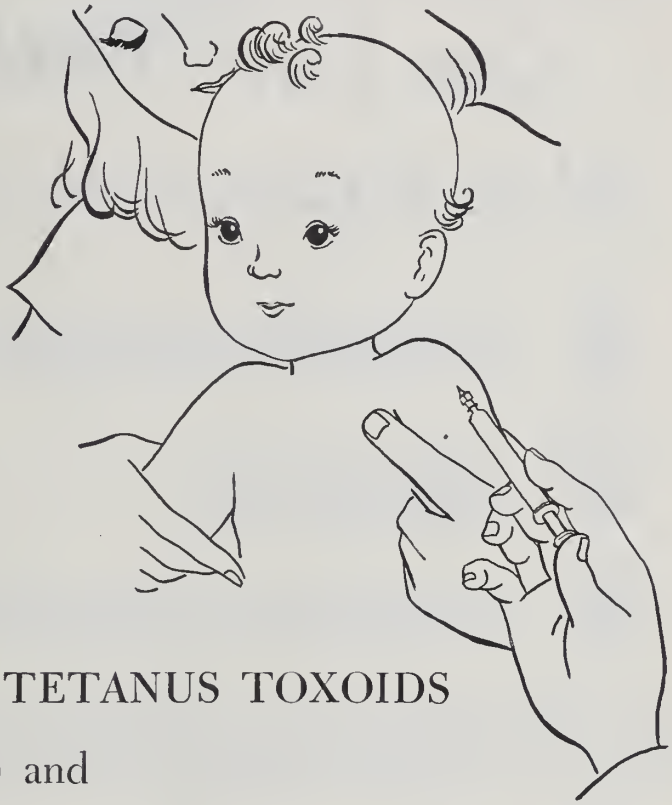
As is readily seen in the chart above, every kind of meat is an excellent source of high quality protein and of iron. Meat further supplies significant amounts of the three B complex vitamins, thiamine, riboflavin and niacin. Certain cuts and kinds of meat are, as a matter of fact, among our richest food sources of thiamine and niacin. All meat, regardless of grade or cut, makes these contributions.

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3. Salt . . . . . 0.2 lbs.
4. Soybean Meal 0.5 lbs.
5. Gluten Feed 0.5 lbs.
6. Linseed Meal 0.1 lb.
7. Distillers Grain 0.5 lb.
8. Brewers Grain 0.5 lb.
9. Bran . . . . . 1.5 lbs.
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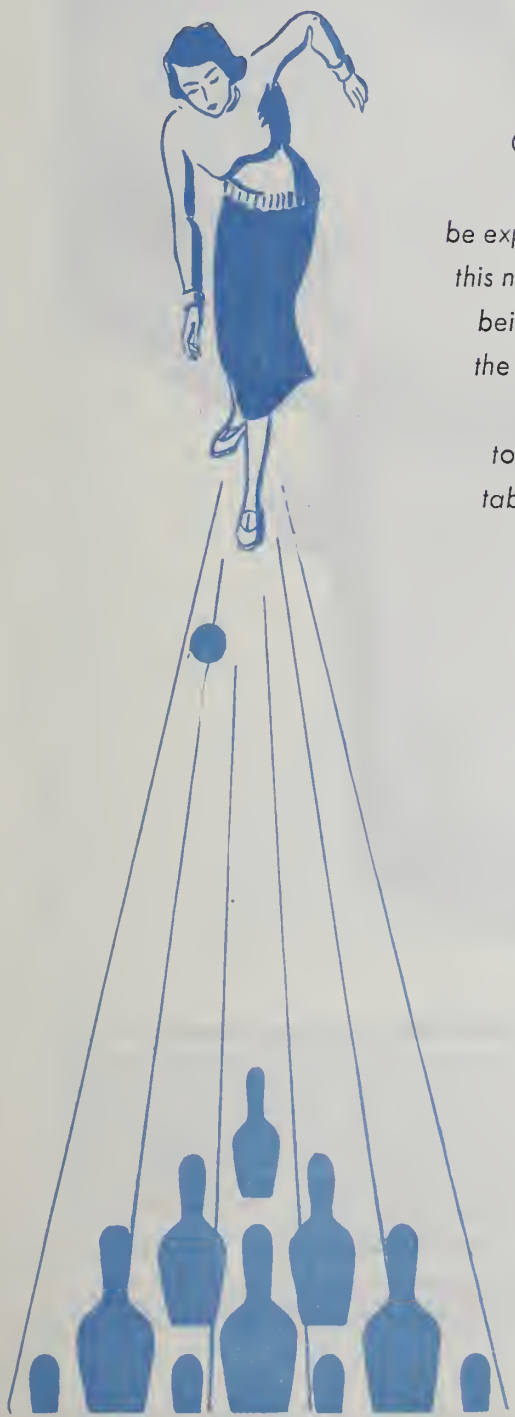
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*Downing, J. G., Hanson, M. C. and Lamb, M.: Use of 5-Nitro-2-Furaldehyde Semicarbazone in Dermatology, J. A. M. A. *133*:299, 1947. • Shipley, E. R. and Dodd, M. C.: Clinical Observations on Furacin Soluble Dressing in the Treatment of Surface Infections, Surg. Gynec. & Obst. *84*:366, 1947. • Miller, J., Rodriquez, J. and Domonkos, A.: Evaluation of Penicillin in Topical Therapy, New York State J. Med. *47*:2316, 1947.

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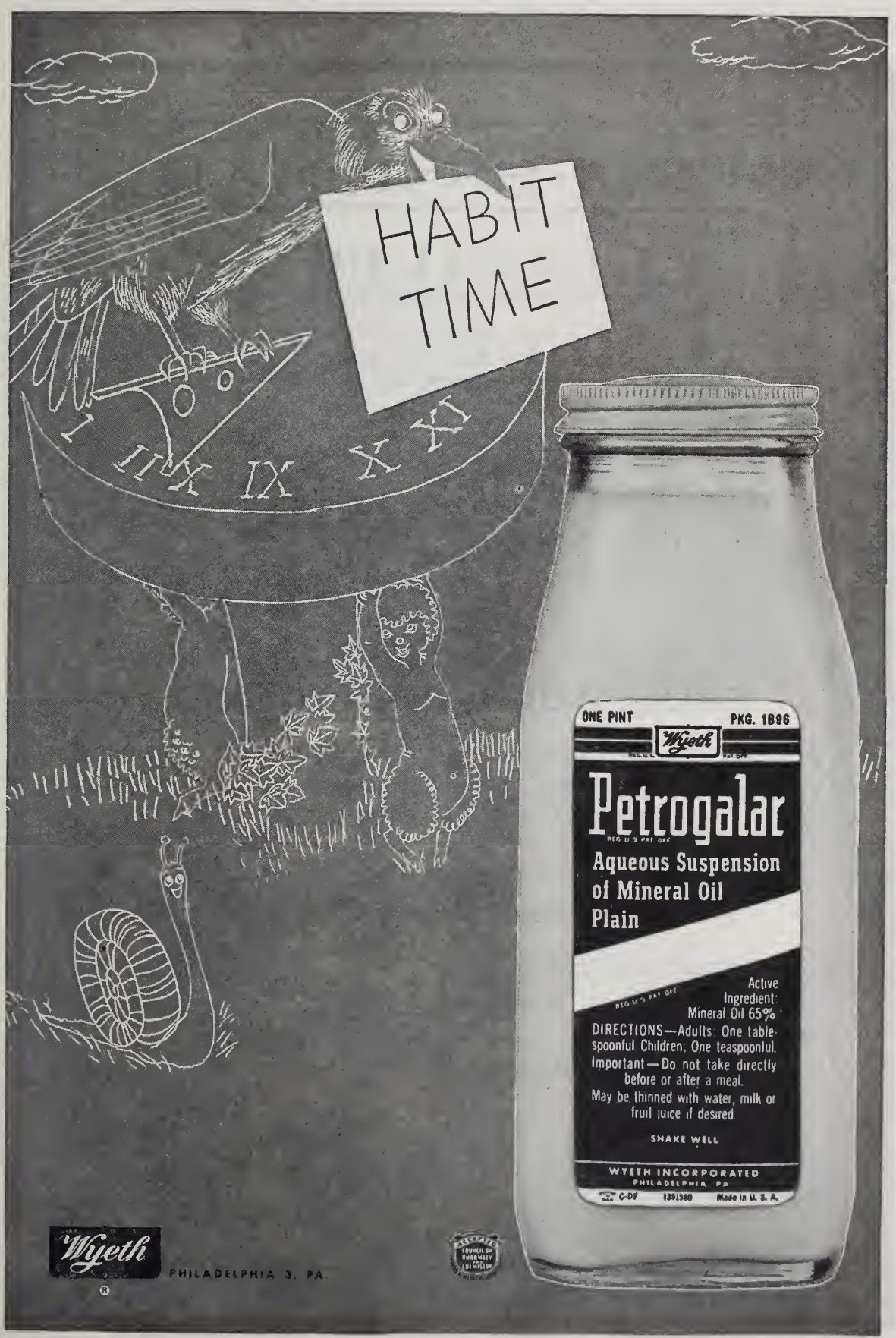
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*Rakoff, A. E.; Paschkis, K. E. and Cantarow, A.: A Clinical Evaluation of Dienestrol, a Synthetic Estrogen, J. Clin. Endocrinol., 7:688-700 (Oct.) 1947.

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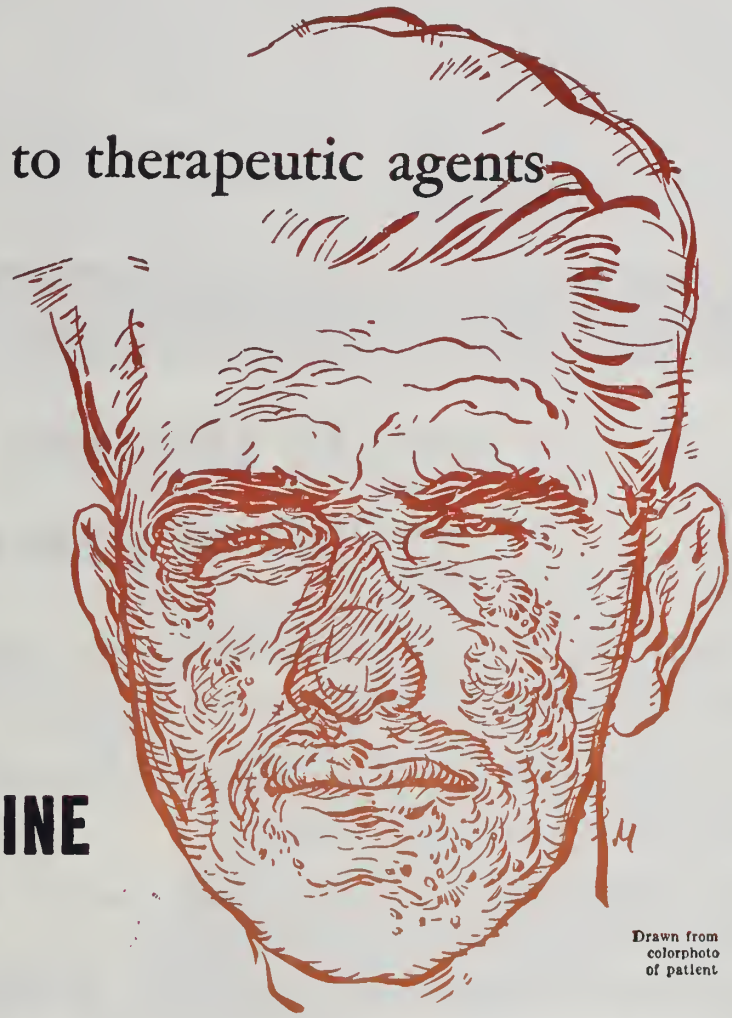
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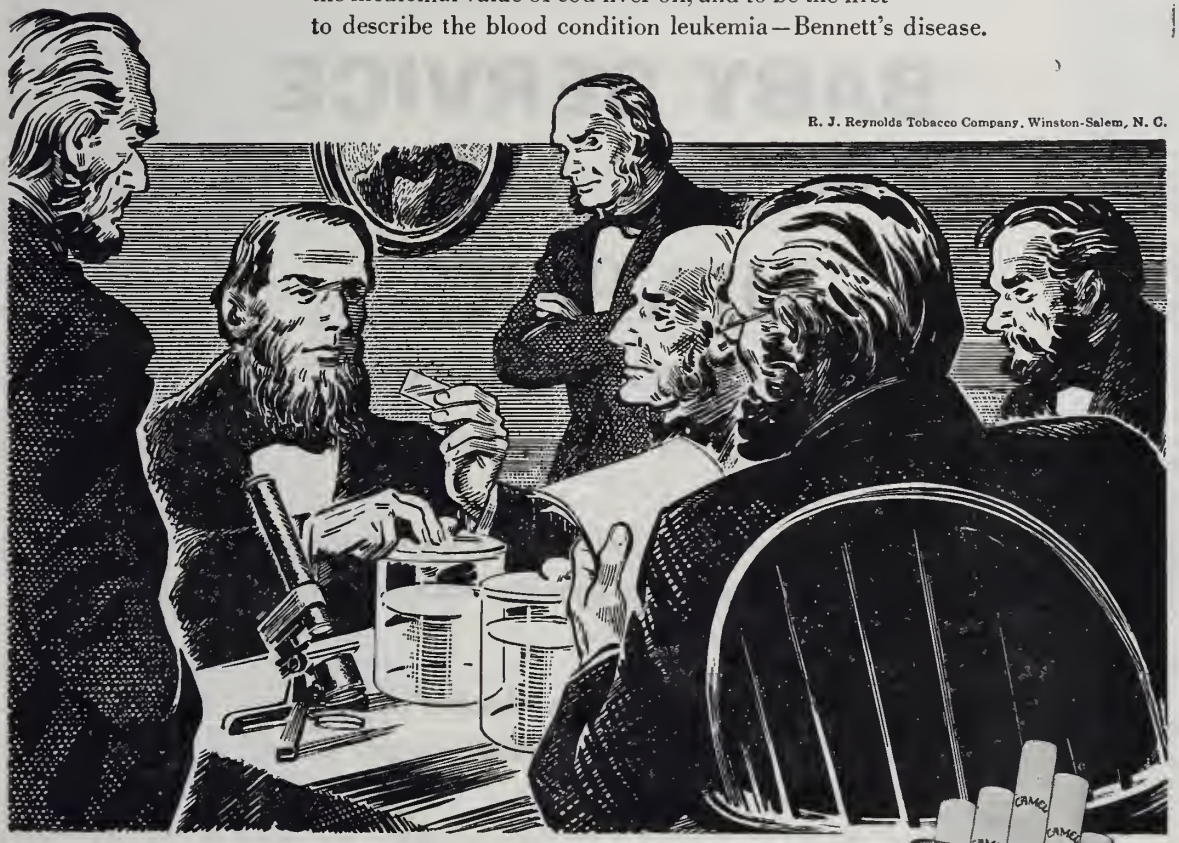


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PRESIDENT'S MESSAGE

With the advent of another Thanksgiving Day, it might be well to cast our eyes back over the events of the last year or so, taking note of some of the things for which we may rightly be thankful. We do so, however, with no complacency, in no spirit of smug satisfaction, but with a keen realization that almost any one of these favorable developments might easily be canceled out in the year to come should we relax our vigilance or fail to meet our opportunities.

First, we may be thankful for the fact that all over the United States, the medical profession seems to have come alive to the need for taking the public into our confidence, the need for creating and acquiring the good will of the general public. What is more, I think we doctors have at last awakened to a full acceptance of the fact that good public relations depend not on what we say about ourselves but what we do for the public.

Hence, the number one item on my Thanksgiving list is the spectacle of organized medicine throughout the country commencing to take its full part in public affairs. Gone are the days of professional isolationism and insular disregard of how the public feels about us.

Our second cause for thanksgiving stems from and is a part of the first. I refer to the nation-wide growth of the voluntary prepayment plans which are enabling more and more workers to purchase essential medical security for themselves and their families. By the end of this year, prepayment programs will be operating under the auspices of medical societies in every state in the union and their rate of growth in the last three years has been even faster than that of the Blue-Cross hospital program in its infant period. Not only does the mushrooming success of voluntary health insurance promise to obviate all excuse for government interference in medical care,

but it should furnish for all Americans an inspiring example of what can be done to solve social problems by voluntary action.

Despite the re-election of a national administration known to favor health insurance, we may take considerable satisfaction, I think, in the gradual but unmistakable discrediting of compulsory health insurance as the most desirable method of solving admitted deficiencies in the distribution of medical care. The report of the Brookings Institution, prepared at the request of our own Senator H. Alexander Smith, and the masterful expose of the misuse of draft board statistics by Dr. Maurice Friedman — these two events comprised the one-two punch that have put the proponents of compulsory government health insurance on the defensive for the first time in many years.

A fourth cause for gratification for all of us, but especially for your president, is the enthusiastic way in which the officers, committee men and staff not only of the State Society but of the county societies—and the members at large—have been devoting themselves to our Society's affairs. The year thus far has been marked not so much by the evolution of new policies and the announcement of new programs as by the tougher, less spectacular, but perhaps more essential work of making our plans and programs come alive. Our celebration of "Public Health Week", the negotiation of our new plan for old age assistance patients, our participation in planning the administration of the cash sickness program, the establishment of round-the-clock emergency medical service plans, our cancer educational meetings, our long and apparently successful negotiations for the proper disposition of the professional boards—these are but a few of the solid accomplishments recorded during this and the immediately preceding administrative regime.

There is, indeed, much to be thankful for, but there is no excuse for even one iota of complacency. In medical affairs, as in most other departments of life, the more one does, the more one discovers there is yet to do. Let's be thankful, therefore, but let's get to work even more earnestly than ever!

J. Howard Hornberger, M.D.
President.

DIABETES AND THE DOCTOR'S DILEMMA

December 6 begins "National Diabetes Week". This offers a platform for the development of diabetes consciousness among the public and profession alike. Here is a treatable disease, with new and powerful remedies available — and it is public enemy number 8 in the roster of causes of death! Next month's special program provides an opportunity for publicizing a full scale attack on the disease. Diagnosis is certainly not difficult, and every family doctor can take the necessary specimens and order the necessary tests. He can if—and here's the rub —if he happens to think of it. This is a good time to start thinking of it. This is still the doctor's (particularly the general practitioner's) opportunity. Will he seize it or surrender the responsibility to others?

ORIGINAL ARTICLES

MODIFIED ELECTRO-SHOCK THERAPY AND RAPID TREATMENT OF MENTAL ILLNESS *

Vincent J. Riggs, M.D., East Orange, N. J.

Electro-shock therapy is a physiologic form of treatment of mental illness of established curative value. The actual changes which take place in the brain are still unknown. However, we do know that pure physical shock or psychologic trauma play no part in this cure. The severe muscular reaction which takes place is a result of the electrical stimulation of the motor areas and is not directly associated with the curative value of the treatment. The beneficial effect arises from some change in the intellectual or emotional regions of the brain.

All shock therapies have one common denominator: an electrical brain reaction. Even insulin is not highly effective until the coma or convulsive stage is reached; in other words, until an "electrical" brain reaction occurs. With modified electro-shock, we are attempting to produce this electrical reaction with less physical violence to the patient.

The form of electro-shock therapy I have used is a moderation of the electro-narcosis technic of Dr. Thompson and his associates of California. This variation was suggested to me by Dr. Clarence W. Olsen of Berkeley, California, who had been using this treatment. He advised that the current be kept at 200 milliammeters for only ten seconds instead of the prolonged electro-narcosis treatment of seven minutes. This moderation allowed a tremendous safety margin in the dosage of electricity used. Later, the duration of treatment was increased to between 20 and 30 seconds, without any apparent undue hardship to the patient.

TECHNIC

A milliammeter equipped electro-shock machine is used, the milliammeter replacing the voltmeter. An additional timer is required, calibrated from two to thirty seconds. The treatment dial is set at zero. After the current is switched on, the treatment dial is turned slowly, raising the amperage from zero to 200 milliammeters. After ten seconds, the rate is reduced to 100 milliammeters and the flow of electricity is allowed to continue until automatically shut off at the time set, usually between 20 and 30 seconds.

The patient responds by slowly going into a tonic state which is maintained until the current turns off. Then, there are a number of clonic movements. There is no convulsive stage unless the dosage is too high. There may be a short excitement stage but usually there is not. The patient sleeps for about ten minutes and is ready to leave the office in a half hour.

Of importance in the technic is the setting of the treatment dial at zero. This refinement in method was suggested by Dr. William R. Rosanoff, of California. It almost completely removes the sudden brisk flexion of the standard electro-shock.

With this therapy, the dosage of electricity may be calculated quantitatively and expressed in coulombs. This is obtained by multiplying the milliamperage by the number of seconds the current was used. One coulomb is the quantity of electricity used at the rate of one ampere for one second.

ADVANTAGES

1. The initial brisk flexion is avoided, reducing the possibility of fractures and dislocations.

2. The power of the muscular contractions throughout the treatment is lessened, also re-

* Read before the New Jersey Neuro-Psychiatric Association, March 17, 1948. Five recovered cases were presented, two of whom had undergone rapid treatment, cases 2 and 5. The modified form of shock treatment was demonstrated on another patient.

ducing the possibility of fractures and dislocations.

3. Curare, which is in itself a hazard, is not required.

4. If the patient has a severe body handicap the dosage may be reduced, adjusting the treatment according to the patient's physical condition.

5. Treatment may be administered more frequently, effecting a more rapid cure.

RESULTS

Beginning in August 1946, this modified form of treatment was administered to all of my patients who received shock therapy. Fifty-eight were actually treated between August 1946 and March 1948. A report, however, is being made on only 55 patients, as three failed to complete treatment. All were private patients; 52 were treated in the office and three in private rooms at a general hospital.

Of the 55 cases, 28 recovered, 20 were improved and 7 unimproved. The recovery rate was thus 51 per cent, and the ratio of improved or recovered patients was 88 per cent. The percentages, of course, are on cases selected as suitable for shock therapy.

Headache, backache and muscle or joint pains were infrequent

Memory loss was moderate, and usually not noticeable after two weeks' time. There were no accidents or injuries.

The average number of treatments administered per patient was, at first, ten treatments; that is, when the duration of each treatment was ten seconds. When the duration of the treatment was lengthened to over twenty seconds, an average of only seven treatments was required, the dosage administered being between three and four coulombs per treatment.

In the depressive group there were 36 cases. Of these 23 recovered, 9 improved and 4 remained unimproved.

Of special interest are some sub-standard physical types: All were treated without incident. These included:

(A) A woman 80 years old.

(B) A young woman who was undergoing pneumo-thorax treatments and had an air injection the day before shock therapy was started.

(C) A young woman who was 13 days post-partum. She had been delivered by caesarian section.

(D) A woman with severe valvular heart disease, both aortic and mitral. Her blood pressure was 180/0. In her case, the treatment was administered at 200 milliamperes for only four seconds, and 100 milliamperes for only eight seconds.

RAPID TREATMENT

Dr. Lothar B. Kalinowsky has used rapid treatment in manics. He administered two or three treatments a day and has reported remissions in only two or three days' time. Using this as a guide, I have employed similar rapid therapy in five psychotic cases suitable for office shock treatment.

The treatment was administered on a 12 hour schedule, morning and evening, without evidence of undue strain to the patient. The results were: three recovered promptly, one improved and one was unimproved.

CASE 1

Female, age 21. Post-partum psychosis, severe retarded depression. She said "I'm really dead." The few replies she made were after a retardation period of 15 to 20 seconds. Most of the time she gazed fixedly at the wall or at the desk and from time to time she began crying without apparent reason. She was given a treatment on the morning of the first visit, received another that night, and another the following morning. On each visit, the retardation period was lessened. At the time scheduled for the fourth treatment, she was found to be alert, and cheerful, no longer crying, answered questions promptly, showed insight into her condition. She said she *had* thought she was dead and that she was in an undertaker's office, but no longer had any such idea. Further treatment was not considered necessary. She received only three treatments. This patient was treated in May 1947 and has remained completely well. The total treatment period was only two days.

CASE 2

Female, age 53. Involution melancholia. Depression, insomnia, guilt ideas. One year duration. She received seven treatments, 12 hours apart, and was considered well on the fourth day with only mild memory defect. Her husband, too, considered her completely well, and remarked, "Even seeing it, I can't believe it." This patient was treated in June 1947 and has remained well. Treatment period was was four days.

CASE 3

Female, age 52. Involution melancholia. Insomnia and depression, duration three months. She received seven treatments at 12 hour intervals. She became highly agitated and treatment was stopped. She remained agitated for several days

then lapsed into her former state. This patient remains essentially unimproved. Treatment period for four days.

CASE 4

Female, age 27. Manic-depressive, depressed. Duration one year. Complained of "waves of depression" and of crying without reason. She received six treatments, appeared well, then lapsed somewhat after ten days. She received no further shock therapy and recovered completely after four months of psychotherapy. She was considered as moderately improved as a result of the shock therapy. Treatment period was three days.

CASE 5

Female, age 23. Post-partum psychosis. Schizophrenic reaction. Duration one month. Headaches, insomnia, and highly delusional. Said she was Mother Mary, that she was in Heaven and that her husband was God. She received five treatments at 12 hour intervals. Interviews began on the third day after treatment, and she was found to be completely recovered with only mild memory defect. Treatment period three days.

SUMMARY AND CONCLUSIONS

Electro-shock therapy can be reduced in severity so that curare may be discarded and fractures and dislocations still avoided. This may be accomplished by lowering the amperage and increasing the duration of electric flow.

With this therapy, the period during which treatment is administered, may, in selected cases, be shortened to several days' time.

295 North Arlington Avenue

CLINICAL EXPERIENCE WITH A NEW OXYTOCIC *

J. N. PANNULLO, M.D., Newark, N. J.

Hemorrhage is the most common cause of maternal mortality in this area. The search for means of preventing and reducing such catastrophies led us to an experimental study with a new oxytocic known as methergine,[1] a synthetic ergonovine-like derivative.

Modern obstetrics with its indiscriminate use of analgesics, causing relaxation of the uterus, and early ambulation of patients (many of whom had hemorrhages at home) made us realize the inefficacy of the products we were using.

Methergine solution intravenously was used instead of ergonovine and methergine tablets given orally were substituted for ergoklonin during the puerperium in more than 100 cases.

During the past ten years, in a series of more than 10,000 deliveries our routine procedure has been to give pitocin or pituitrin intramuscularly when the fetal head was crowned and ergonovine intravenously after expulsion of the placenta. This method gave good results. However, when methergine replaced the ergonovine, we had a more prolonged contractile effect with a definite reduction of blood loss.

During the puerperium, one methergine tablet was given every four hours for 48 hours in one series of cases. In these patients the following results were obtained

1. Hyperinvolution of the uterus. It was usually about the level of the symphysis pubis on the fifth day.
2. Marked diminution of lochia.
3. Almost complete absence of lochia after the fourth or fifth day.
4. Absence of after pains in the majority of cases.
5. No bleeding or hemorrhages at home. The usual hospital stay was seven days.

In another series, one methergine tablet was given three times daily with the results not quite as marked as when one tablet was given every four hours.

CONCLUSION

Methergine [1] appears to be a valuable adjunct in obstetrics because:

1. It causes no toxic or adverse systemic effect.
2. It diminishes blood loss by its prolonged contractile effect on the post-partum uterus.
3. It hastens involution and
4. It may prevent re-admission of patients for bleeding in hospitals where early ambulation is practiced.

*Read before the Scientific Meeting of Presbyterian Hospital, Newark, N. J., August 27, 1948.

1. Supplied by Sandoz Chemical Works, Inc.

266 Van Buren Street

TREATMENT OF COLLES' FRACTURE

BAXTER L. CLEMENT, M.D., F.A.C.S.,
Newark, New Jersey

This paper is based on a study of the end results in a large series of Colles' fractures in which the post-reduction position and the functional recovery were universally poor. The explanation for this is that we neglect certain fundamental principles of practice herein set forth. To appreciate what takes place when the lower end of the radius is fractured, it is necessary to understand the normal anatomy of the bone. From this study, it was obvious that insufficient attention has been given to correction of the displaced tilt of the articular surface of the radius.

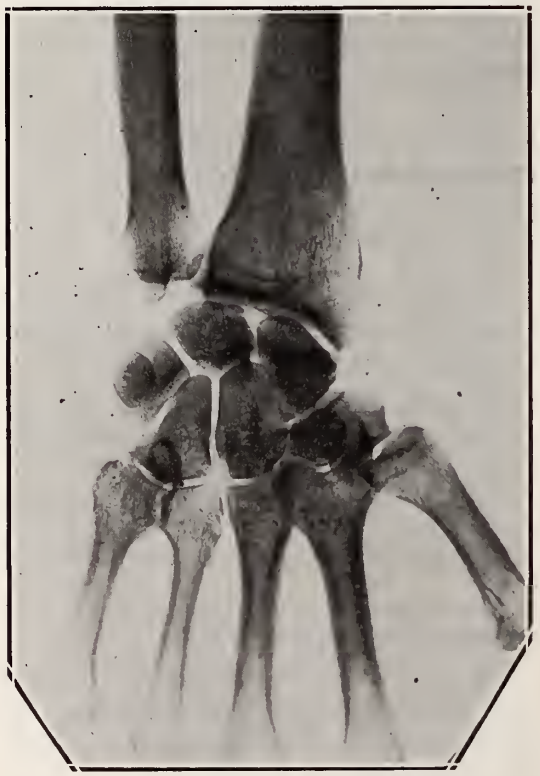


FIGURE 1



FIGURE 2

Anteroposterior x-ray of a normal wrist (Figure 1) reveals the concave articular surface of the radius to face ulnarward at an angle of about 25 degrees, and the styloid process of the radius to extend distally about ⅜ of an inch beyond that of the ulna. In the lateral view (Figure 2) the articular surface of the radius faces downward toward the palm at an angle of 10 to 15 degrees. Of the two views, the lateral is the more important and a plea is made at this time for *accurate measurements of the displacement,* before and after reduction, as a part of the permanent x-ray record.

X-ray of a typical Colles' fracture (Figure 3) reveals the usual displacement: the dorsal tilt of the articular surface of the radius and a decrease in the anteroposterior angle of from 15 to 20 degrees.

Unless reduction of these fractures will anatomically restore these normal relationships, there can be only a partial functional recovery. Painful wrist, impaired motion, loss of grip, radial deviation of the hand and a prominent ulnar styloid may be anticipated. The ratio

of disability is in direct proportion to the normal replacement of the articular tilt.

First step in the treatment of these fractures is the analysis of satisfactory anteroposterior and lateral x-ray films. By this, the degree of displacement which must be corrected is determined and the proper maneuvers for reduction intelligently planned.

Early reduction under complete muscular relaxation is imperative. This can be accomplished only by a well-administered general anesthesia. Local anesthesia has not proved satisfactory and should not be used unless there is a definite contraindication to general anesthesia.



FIGURE 3

REDUCTION

The patient is placed on the operating or fracture table and traction is applied to the fingers and thumb with efficient counter traction. Do not hurry this process. Traction must be continuous and even. This is difficult to achieve manually. A more efficient traction can be obtained from use of the finger-trap attachment. The operator is thus permitted complete use of both hands for the manipulation of the fragments and application of the plaster without loss of reduction. After completion of reduction and before application of the plaster, x-rays should be taken and the articular angle carefully measured, if not satisfactory further manipulation is imperative. I mention the fluoroscope at this time only to condemn its use. If reduction, as disclosed by radiographic study is satisfactory, position usually can be maintained with the wrist in a neutral position or with slight palmar and ulnar dejection. The extreme palmar flexion or the Cotton-Loder position should not be used. However, the type of immobilization varies. Reduction can best be maintained by the "sugar tong" type splint reinforced with circular plaster. Here again, the continuous, steady pull of the finger traction apparatus is advantageous, allowing the operator more maneuverability. The splint must be carefully prepared, evenly rolled, having no wrinkles. It should extend from a half inch proximal to the metacarpophalangeal joint on the dorsum encircling the elbow with the wrist and forearm in mid-supination and pronation, extending over the volar surface of the forearm extending just proximal to the metacarpophalangeal point.

The splint is now trimmed at the wrist so that the plaster edges will not overlap, it is also cut over the thenar eminence. The splint is then encased in circular plaster extending just distal to the elbow joint and ending proximal to the metacarpophalangeal joint. When properly applied the splint permits complete flexion in all of the interphalangeal and metacarpophalangeal joints. It also greatly prevents supination and pronation of the forearm and at the same time does not completely restrict elbow motion.

Post-operatively, the patient is instructed to use the fingers daily, not only actively moving them through their maximum range but at all times to employ normal daily use. Secondly, to abduct, anteriorly elevate, internally and externally rotate the shoulder through its maximum range several times daily. By this simple procedure a frozen shoulder can be prevented.

If there is post-reduction swelling accompanied by pain and edema of the fingers no time should be lost in bivalving the cast. There is usually no disturbance of the reduction and a circular plaster should be re-applied when the swelling has subsided.

Because of the tendency to recurrence of the deformity if immobilization is removed too early it is recommended that the "sugar tong" splint remain undisturbed for a minimum of five weeks.

SUMMARY

1. Malunited Colles' fractures are too common and result from lack of attention to fundamental principles.

2. Careful study of pre-reduction x-rays regarding disturbances of articular tilt is imperative.

3. Early reduction is advised.

4. General anesthesia is essential for complete relaxation.

5. Continuous even traction by the finger-trap attachment is advised.

6. Complete correction of impaction and dorsal tilt is important.

7. Advantages of the "sugar tong" splint are described.

8. Minimum of five weeks immobilization should be allowed.

9. The necessity of free finger motions and daily use of fingers and shoulder joints are stressed.

15 Washington Street

HONOR TO DR. DECKER

On the 50th anniversary of the date of his entry into private practice, Dr. Frederick H. Decker of Frenchtown was honored by his colleagues of the Hunterdon County Medical Society. Meeting in Flemington on October 26, the officers and members of the Hunterdon County society presented to Dr. Decker a scroll of honor and a gold key to mark his admission into the select company of physicians who had remained consistently in practice for half a century. Twice honored by his fellow-townsmen by selection as mayor of Frenchtown, Dr. Decker was hailed as a prime example of the real general practitioner who had for that long period steadfastly upheld the best traditions of the brotherhood of Aesculapius. The presentation speech was made by Dr. Barclay S. Fuhrmann, Councilor of The Medical Society of New Jersey and Treasurer of the Hunterdon County Medical Society.

JOURNAL OF ELECTRO-ENCEPHALOGRAPHY AND NEUROPHYSIOLOGY

Announcement is made of a new medical periodical which, it is promised, will "bring together in one publication, selected studies in the growing field of clinical neurophysiology and to provide an organ for the various electro-encephalographic societies". The journal will be published in English with abstracts of all articles in French and Spanish. Editor in Chief will be Herbert Jasper of the Montreal Neurologic Institute. Subscription rate is $8.00 a year. Physicians in the U. S. A. who desire to subscribe should forward this remittance before December 31 to Dr. Robert Schwab, Massachusetts General Hospital, Boston 14, Massachusetts. As the first issue of the *Journal of Electro-Encephalography and Clinical Neurophysiology* will be February 1, those whose subscriptions are in by the end of this year (Dec. 31, 1948) will become charter subscribers.

SELECTION OF ANESTHESIA FOR THE PATIENT WITH MEDICAL COMPLICATIONS *

Henry S. Ruth, M.D., Haverford, Pa.

Surgical procedures of long duration are no longer a rarity, no matter which cavity of the body is invaded. Advances in anesthesiologic practices have certainly contributed largely to this success. In the field of anesthesia, results depend more on the skill and experience of the anesthetist than on the inherent characteristics of the agent or methods employed.

Generally speaking, it is the practice to select the anesthesia on the following basis and in the order indicated: (1) safety to patient, both immediate and from the long range viewpoint, (2) facility for the surgical manipulations, and (3) comfort for the patient in all its aspects. After these principles, consideration is given to four additional factors each of similar import: (A) the surgeon, (B) the anesthetist, (C) the surgical procedure, and (D) the patient's disease or diseases. *Within the limits of safety to the patient,* the anesthesia should be selected which is most likely to meet the surgeon's requirements. To do this, his skill and dexterity should be considered, even though not expressed by the anesthetist, and likewise, his expectancy of or need for muscular relaxation. The abilities of the anesthetist and the extent of his experience is always important. The duration and type of the surgical procedure and the depth or extent of anesthesia required are important. Lastly, in respect to the patient's disease, consideration is given on one hand to the relationship between the pharmacologic action of anesthetic drugs, and the factors concerned in the methods of their administration; and the underlying disease of the patient on the other hand.

How about anesthesia for the patient with medical complications? It is not economically feasible to have an internist examine each prospective surgical patient in ordinary situations, in spite of its desirability. Here a qualified anesthesiologist with a basic knowledge of medicine can exhibit another valuable facet of his activities. In the routine preoperative evaluation of each patient, he should be able to determine previously unrecognized medical complications. When they are serious, a consultation by an internist for their evaluation is indicated. What role should the internist play in this picture, in well organized surgical teams? The complete diagnosis of the medical aspects and the evaluation of the medical status is expected, and should be recorded. If the patient is inoperable, it should be so stated. If medical treatment is indicated before surgery and anesthesia can be performed safely, its definitive nature should be suggested. If medical complications are present and serious but do not countermand surgery, the internist may suggest the type of anesthesia, or specifically contraindicate one or more types. This is not advantageous ordinarily when a competent anesthesiologist is a member of the team. An internist usually spends little of his time in the surgical amphitheater, and therefore, under average circumstances, cannot have intimate knowledge through personal experience either of the surgical requirements or the problems of anesthesiology. If more is required by a given situation than an expression of the findings, the best procedure is joint consultation between surgeon, internist and anesthesiologist. In this way, each will learn the other's conception of the problems involved. In a continued difference of opinion, rather than calling in a second internist, consultation with a second, qualified anesthesiologist has been suggested.[1]

DISEASE OF NUTRITION

Malnutrition is encountered frequently in our geographic area. These patients suffer from diminished caloric intake and exhibit de-

* From the Department of Anesthesiology, The Hahnemann Medical College and Hospital of Philadelphia, Penna. This paper was read, by invitation, before the Section on Anesthesiology, Annual Meeting of The Medical Society of New Jersey, April 29, 1948.

1. Macintosh, R. R., and Bannister, F. B.: *Essentials of General Anesthesia,* ed. 3, Springfield, Charles C. Thomas, (1945).

ficiencies of proteins, essential fatty acids, vitamins, and essential minerals.[2] They may show deficiency of water balance, and therefore an anhydremia. Where possible, they are restored to normal physiologic conditions before surgery is instituted. If time is not available to accomplish this objective, adequate anesthesia can usually be accomplished without massive doses. These patients exhibit marked susceptibility to anesthetic drugs. Regional anesthesia should be the first thought wherever it is applicable. If the demands of surgery preclude its use, a combination of regional methods and very light inhalation anesthesia usually suffices. Spinal anesthesia is usually not appropriate, because of the decrease in circulating blood volume. The least amount of depressant drugs for minimal surgical requirements should be the objective, so that the earliest return to a non-depressive state, consciousness, and the ability to provide nutritional needs by mouth are established as rapidly as possible.

When *obesity* is hypometabolic in origin, the patient is readily depressed and therefore easily susceptible to anesthetic agents even in decreased quantities. Technical difficulties are increased when obesity is moderate to severe. Surgical manipulations are hampered, especially when intraperitoneal, and adequate respiratory mechanics cannot be efficiently maintained usually by the use of the simpler methods of general anesthesia. Spinal anesthesia facilitates greatly surgical manipulations in the fat individual. When spinal anesthesia is not advisable, endotracheal methods are indicated for intra-abdominal procedures, as well as for others when they will be prolonged. If shock on the table is a possibility (or when using spinal anesthesia) a preliminary venipuncture or "cut-down" is advisable, especially if the patient's veins are obscure. When obesity is not due to a hypometabolic state, reactions to anesthesia are normal, but the technical difficulties remain unchanged. In both types, large amounts of ethyl ether probably should be avoided, for lipoid deposits retain quantities of this agent, releasing it rather slowly into the blood stream, and the reaction period may be prolonged undesirably.

DISORDERS OF THE DIGESTIVE TRACT

When *liver disease* is severe, especially if associated with jaundice, the glycogen reserve should be built up preoperatively by the administration of dextrose, with or without insulin and a high protein diet. To stabilize the protein molecule, chloride ions are necessary.[3] On the other hand, overchlorination will produce salt retention and edema. Secondary anemia of major import is common with many forms of liver disease. A high icteric index increases the possibility of major blood loss, through delayed coagulation time. Chloroform, ethyl chloride and tribromethanol are usually contraindicated. Use of ethyl ether should be restricted to minimal supplemental amounts. Most barbiturates are not acceptable with major hepatic destruction but barbital, phenobarbital and possibly small quantities of pentothal are exceptions.[4,5] Increased liver damage by any anesthesia is readily accomplished by relatively minor degrees of oxygen want. Some clinicians fear the hypoxia of the blood pressure fall of spinal anesthesia in this condition. Cyclopropane or ether appear to cause no fall in the plasma prothrombin in the uncomplicated cases.[6] Cyclopropane or spinal anesthesia, depending on other factors for the final selection, are our usual choices.

The anesthesiologic management of *obstruction of the intestine* is a controversial problem. The indication for decompression, the hemo-concentration due to vomiting, the increased non-protein nitrogen or blood urea nitrogen, the decrease of blood chloride, and an increased carbon dioxide combining power of the blood present a complicated picture. If fairly efficient preoperative decompression is not permissible or possible, spinal anesthesia usually provides the greatest degree of facility for surgical manipulations. Some still fear the possibility of intestinal perforation through the increased peristaltic

2. Albrecht, F. K.: *Modern Management in Clinical Medicine,* Baltimore, Williams and Wilkins Co., (1946).
3. Best, C. H., and Taylor, N. B.: *The Physiologic Basis of Medical Practice,* ed. 3, Baltimore, Williams and Wilkins Co., (1943).
4. Masson, G., and Beland, E.: Anesthesiology, 6:483, (Sept. 1945).
5. Scheifley, C. H.: Anesthesiology, 7:263, (May, 1946).
6. Cullen, S. C., Ziffren, S. E., Gibson, R. B., and Smith, H. P.: Journal of the American Medical Association, 115:991, (Sept. 21, 1940).

movements provided by spinal anesthesia. It is a question, however, whether distended intestines (making the use of spinal anesthesia so acceptable) can contract to the extent that a perforation can more readily occur.[7] This type of anesthesia should not be employed if surgical intervention is demanded in the presence of shock. Here we have found bilateral subcostal block (at the sixth to eleventh thoracic segments) and light cyclopropane anesthesia acceptable and adequate. The combination of continuous spinal anesthesia with the anesthetic agent in concentrations of 0.5 per cent or less as injected, for temporary and transient depression of the sympathetic system in conjuction with regional anesthesia of the abdominal wall offers interesting possibilities.

How about *pancreatitis?* If this be of the interacinar type associated with glycosuria, the patient should be managed similarly to that of a diabetic patient. If a surgical procedure is contemplated in the presence of shock with acute pancreatitis, the general rules for anesthesia in shock prevail.

DISEASES OF BLOOD AND BLOOD FORMING ORGANS

All of the anemias exhibit a reduction of the oxygen capacity of the blood. This is why it is illegal in some states to administer an anesthesia without a hemoglobin estimation and a red blood cell count. The anesthetic procedure should always allow the inhalation of high oxygen concentration. Nitrous oxide and oxygen uncombined have dangerous possibilities even in experienced hands for short durations. Only five Grams of reduced hemoglobin in the blood stream are required to produce the phenomenon of cyanosis.[3] For this reason patients may be placed in a morbid or a lethal state without cyanosis when severely anemic. Agents that produce *depression* of respiratory function are likewise contraindicated in moderate and severe anemias, unless normal minute volume ventilation of the lungs is maintained, as for example, by augmented respiratory movements, or controlled respiratory function with the use of closed systems.[8] In deep cyclopropane anesthesia in the presence of anemia, respiratory function should be augmented to maintain normal or increased respiratory volume. Frequently the fact is overlooked that atmospheres of high oxygen content can be administered with ether in the closed systems. Dogmatic proponents of cyclopropane may be responsible, for this statement is made rarely in their writings. Patent respiratory passages, as well as elevated oxygen intake, should be continuously maintained in severe anemia. Intravenous pentothal, if administered slowly (for procedures where a great depth of anesthesia and extensive muscular relaxation are not required) may be given cautiously, but an increase in the oxygen content of the inspired atmosphere is desirable. In severe anemias, the spleen is fairly well drained of erythrocytes. Therefore, in borderline cases, the effect of the barbiturates causing the spleen to take up erythrocytes from the circulating blood and decrease the already low hemo-concentration may be important. Spinal anesthesia is feared usually with a hemoglobin content below 60 per cent or 9 Grams, because of unavoidable hypotension and respiratory depression, particularly in high spinal anesthesia.

Pernicious anemia sometimes causes changes in the spinal cord. Mild, indefinite paresthesias and impaired vibratory sensation in suspected cases should indicate caution, even in the absence of pronounced symptoms.[2] Spinal anesthesia is best avoided, when these symptoms are present. As Damshek has said, the neurologic lesions of pernicious anemia may be out of all proportion to the blood picture. It would appear from reports in the literature and from unreported cases, that neurologic lesions may be precipitated readily by the use of spinal anesthesia in the presence of pernicious anemia. The importance of this from the medico-legal viewpoint needs no further comment.

Occasionally, surgical intervention is indicated in patients suffering from *polycythemia vera*. The important aspects of this condition from the viewpoint of anesthesia are an increased basal metabolic rate, a reduced blood circulation rate, and a tendency to thrombosis.

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7. Helm, J. D., Jr., and Ingelfinger, F. J.: Surgery, Gynecology and Obstetrics, 79:553, (Nov., 1944).
8. Drinker, C. K.: *Pulmonary Edema and Inflammation*, Cambridge, Harvard University Press, (1945).

The latter is likewise present in symptomatic polycythemia, which occurs when nature attempts to compensate for the interference with oxygenation of the blood; as for example in congenital heart disease, persistent exposure to high altitudes, metahemoglobinemia or sulphemoglobinemia. In these conditions ethyl ether, chloroform, ethyl chloride and avertin are contraindicated, or should be used sparingly. These agents each possess one or more of the characteristics of decreased clotting time, decreased circulation time, falling blood pressure, decreased cardiac out-put, and increase in the number of erythrocytes. Spinal anesthesia, intravenous barbiturates, or cyclopropane produce less interference in the polycythemias. Atropine (but not scopolamine) counteracts the bartiturate and morphine effect of lowering the prothrombin time.[9]

DISEASES OF THE HEART

Of general consideration in the evaluation of cardiopathies is the vital capacity of the patient, which is indicative of the reestablishment of the cardiac reserve or lack of it. The degree of dyspnea under normal basic conditions is a good index of the degree of reserve present. A differential diagnosis between cardiac dyspnea and pulmonary dyspnea can be made by a determination of the velocity of the blood flow, which is decreased in cardiac dyspnea and unchanged or increased in dyspnea of pulmonary origin. There are two important exceptions to this rule for a hyperthyroid cardiac or severely anemic patient can show an increased blood flow because of peripheral dilatation or increased cardiac out-put, even in cardiac failure.[10] The determination of venous pressure will provide a differential diagnosis between edema of cardiac or non-cardiac origin, such as portal or other venous obstruction.

Anesthesia in a patient with *compensated cardiac disease* is not complicated provided that decreased oxygen intake is avoided. *Uncompensated cardiac disease* with congestive failure is always a serious problem. Regional anesthesia with adequate sedation eliminating apprehension, should be the first choice. Recently, anesthesiologists have employed spinal anesthesia with some success in this condition. Of the gases used for anesthesia, cyclopropane is the only one of any merit of its accompanying high oxygen content. On the other hand, a seriously damaged myocardium is considered more susceptible to conduction disturbances, which are not uncommon in cyclopropane anesthesia in normal hearts. If the gases are not adaptable to the situation, ethyl ether administered without high concentrations, (breath - holding, coughing and mucus secretions) volatilized with pure oxygen, appears to be a proper choice for inhalation anesthesia. Cardiac dyspnea is believed to be a contraindication to intravenous pentothal. The maintenance of a good airway throughout inhalation anesthesia is of prime importance. An efficient airway is best supplied by endotracheal methods instituted after anesthesia of sufficient depth has been established so that the insertion of the tube will not produce coughing, breath-holding or other reflex phenomena.

Surgery in the presence of *coronary sclerosis* or *coronary thrombosis* indicates that the time element is important, for the less time consumed by surgery and anesthesia, the less marked is the added load on the cardiovascular system.[11] The anesthesia requires intimate attention to both adequate oxygen intake and maintenance of blood pressure, particularly the diastolic level. If the latter is not maintained, even though oxygen intake is adequate, the supply of oxygen to the cardiac muscle may not be sufficient to continue function. Myocardial infarction may be initiated or increased by a precipitous fall in blood pressure. Sudden death from myocardial infarction may be due to reflex coronary vasoconstriction, and need not be so extensive that muscular failure is responsible.[12] For this reason we usually do not use spinal anesthesia for surgery in the presence of coronary deficiencies. Anesthesia should be induced quickly, without physical activity, and anoxia. If cardiac dyspnea is not present at the time of induction, unconscious-

9. Levy, S., and Conroy, L.: Anesthesiology, 7:276, (May, 1946).
10. Stead, E. A., Durham, N. C., Warren, G. V., and Brannon, E. S.: American Heart Journal, 35:529, (April, 1948).
11. Brumm, H. J., and Willius, F. A.: Journal of the American Medical Association, 112:2377, (June 10, 1939).
12. LeRoy, G. V., and Snider, S. S.: Journal of the American Medical Association, 117:2019, (Dec. 13, 1941).

ness may be instituted by intravenous pentothal here, and in other forms of heart disease. If no arrhythmias are present, and the surgical procedure is intra-abdominal, cyclopropane may then be used in light concentrations until the upper plane of surgical anesthesia is reached, when ethyl ether is carefully added to it, until an adequate depth of anesthesia is reached, without further increasing the concentration of cyclopropane beyond this point.

In *hyperthyroid heart disease,* many of the signs of increased overactivity are not the signs and symptoms of the disease of the heart itself, but rather are the manifestations of the excessive action of thyroxin on the myocardium, as well as the increase in general metabolism. Congestive failure is unusual, except in older age groups with hypertension or coronary artery disease.[2] The outstanding features in respect to anesthesia are the excessive fear of the patient, the decreased cardiac reserve and the tendency toward cardiac arrhythmias. Fewer patients progress to the point of surgical intervention since the advent of propylthiouracil, and when they do, they are less serious operative risks as a rule.[13] Nevertheless, acute surgical conditions can occur before therapy can be made effective, or in that group that do not respond well. If apprehension is remarkable, we have confidence in pentothal administered in the patient's room as we use it for partly controlled toxic thyroids, provided dyspnea is not a prominent feature. The anesthetist goes to the room posing as a laboratory physician ostensibly for a blood test, and, after the venipuncture, sufficient drug is given to produce unconsciousness. The patient is then taken to the operating room, the unconscious state being maintained by small intermittent doses during the trip, where, if muscular relaxation is required, it is supplemented. Subcostal block, unilateral or bilateral, is advantageous. Ether and oxygen without irritation, causing breath-holding, coughing or straining, may be used. Cyclopropane may be questioned, because of its inherent tendency to produce conduction disturbances in the heart. If the surgical procedure is without the abdomen, pentothal may be continued in small doses, augmented by nitrous oxide and oxygen, accompanied by oxygen concentrations never below 25 per cent and preferably higher.

In most instances *cardiac arrhythmias* are harmless, and disappear with induction of acceptable anesthesia, as they do with exercise, or other means of distraction.[14] On the other hand, myocardial damage may be indicated by arrhythmias, especially in the presence of coronary disease with myocardial infarction, and may prognosticate ventricular fibrillation with sudden death. It is our practice not to employ cyclopropane in the face of existing cardiac arrhythmias, except when they have been classified as functional without pathologic or pharmacologic background. Spinal anesthesia, except in coronary disease, has been satisfactory, as have ethyl ether, and pentothal. No matter what the agent and method, the avoidance of struggling or anoxia from any cause is important. A heart that is in poor metabolic condition may be a fertile field for ventricular fibrillation and sudden cardiac arrest during the stress of surgery, although the instances when this occurs are not too common. Systemic epinephrine outpouring by undue struggling and excessive fear, as well as injections of epinephrine, should be avoided even in normal patients when using cyclopropane, because of the possibility of fatal arrhythmias.

Heart block has always carried serious implications. If heart block is due to coronary sclerosis of any magnitude, the patient should be managed as all patients with severe coronary disease should be treated, but if due to localized damage of specific tissue by diphtheria or rheumatic fever, without other damage to the heart, normal precautions should suffice.[14] Only in dire emergency, should operations be carried out if Stokes-Adams syndrome has been present.[15]

So many *hypertensive* patients are brought to a complete, successful, and even uneventful convalescence after a surgical episode, that, if it were not for one factor, we would not fear it as a complication of anesthesia. That factor

13. Harris, C., and Eversole, U. H.: New England Journal of Medicine, 236:829, (May 29, 1947).
14. Scherf, D.: New York State Journal of Medicine, 46:1915, (Sept. 1, 1946).
15. Ernstene, A. C.: Cleveland Clinic Quarterly, 13:189, (October, 1946).

is the unexplainable, rare, sudden death occurring among these patients during surgery. Usually these isolated catastrophies do not occur in patients about whom we are greatly concerned. According to our methods of evaluation of this complication, hundreds of the more "severely handicapped" in this category run comparatively uneventful courses, while the occasional "moderately handicapped" patient succumbs. Consistent with current thought, we recognize the prognostic importance of the combination of the degree of cardiac and renal abnormalities; we avail ourselves of competent evaluation by qualified internists and cardiologists; we avoid spinal anesthesia with possible severe temporary *hypotension* in spite of the usually effective vasopressor drug practices, as well as subsequent renal and other suppressions due to unaccustomed relative, although not true, hypotension. With the few exceptions cited, in the presence of advanced hypertensive heart disease, I have found effective and satisfactory a rapid and smooth induction, usually with pentothal in guarded doses, leaving the needle and syringe *in situ*, followed by cyclopropane. I supplement this combination further by regional anesthetic methods, particlarly if a marked degree of abdominal wall relaxation is required. At this point, I urge caution in injecting local anesthetic drugs in the unconscious patient, particularly in respect to dosage and avoidance of intra-vascular injection. When unconscious, the symptoms of toxic procaine reactions are masked in varying degrees by general anesthesia. Endotracheal technics are frequently employed, especially when a patient's airway cannot be maintained satisfactorily otherwise. During maintenance, possible hypotensions are treated by parenteral fluid administration, intravenously, and vasopressors — never epinephrine — such as ephedrine, methedrine or neosynephrine, cautiously and sparingly, usually intravenously, diluted and slowly. With the combination of cyclopropane and pentothal, if gradually falling blood pressure occurs, I have found it useful to discontinue the pentothal temporarily, and maintain anesthesia with cyclopropane alone. Contrariwise, if increasing hypertension occurs, the administration of cyclopropane is discontinued and pentothal is relied upon. If pentothal is ineffective in reducing the blood pressure, an ampule of amyl nitrite is broken quickly in the ether jar of the anesthetic apparatus, volatilized by the metabolic flow of oxygen, and intermittently added to the mixture in the breathing bag until the situation is under control. Results have been satisfactory where time permits application of this method. The fatalities encountered have been so rapid that little time was provided for the usual method of management. By such management with these agents, results are predominately successful in most cases.

PERIPHERAL VASCULAR DISEASE

The usual surgical procedures in the face of peripheral vascular disease, do not ordinarily call for complicated anesthetic practices. The principles include the avoidance of enhancing the preexisting local and perhaps, systemic anoxia, by an artificially produced oxygen deprivation, the prevention of severe rises or falls in blood pressure, and the protection of the systemic condition of the patient. Intravenous pentothal by the usual, thoughtful injection, regional anesthesia practices, or cyclopropane all have been found adequate. We have not reached the state of perfection where we can glibly *guarantee* anesthesia, by the use of spinal injections, to one lower extremity, completely and unilaterally, or even of complete limitation to the lower body segments, bilaterally, using small doses of hyperbaric solutions in every patient; yet this can be accomplished in most instances. The uncommon and unexpectant extension of spinal anesthesia occurs too frequently in just those cases where it should be avoided. Therefore, we prefer to adhere to other methods.

RENAL AND UROGENITAL DISORDERS

Consideration of anesthesia for this group of patients depends essentially on surgical conditions of this system in (1) the presence of, or (2) absence of the nephritides and (3) acute surgical emergencies in the presence of uremia. Our major interest here, specifically, in the first two cited, is the amount of renal damage and generally, secondary manifestations else-

where. In essentially surgical conditions, it is important to know whether secondary effects have been produced on renal tissue. These are usually managed according to the individual evidence presented for evaluation. Nephritides require caution according to the degree of derangement. Many times (unless faced with malignant hypertension, and even then, at times) spinal anesthesia, since it involves the lower abdomen, alone, usually is of value.

Dependence upon spinal anesthesia to increase the blood supply and therefore the efficiency of the kidney, should not be considered lightly. Enervation of the kidney is controversial, but there is a possibility that vasopressor fibers make their exit from the spinal cord at higher levels, so that spinal anesthesia in ordinary use will not interrupt afferent nerve impulses. For this therapeutic purpose, regional anesthesia at the tenth, eleventh and twelfth thoracic segments, including their corresponding *rami communicantes,* on the affected side, appears to be more logical.

For procedures complicated by the nephritides not requiring excessive muscular relaxation, pentothal usually is adequate and satisfactory. Regional methods are too frequently ignored in urologic procedures, and where the urogenital system should not be subjected to strain. For surgical intervention in uremia, especially if severe, every effort should be made to use regional methods or cyclopropane.

DISEASES OF THE RESPIRATORY SYSTEM

Elective operations should be postponed in the face of acute infections of the upper respiratory tract. There is no excuse for proceeding in spite of them for personal convenience of any one, including the patient. The potentialities, including medico-legal aspects, are too serious. Delay operation, if possible, 48 hours, so that, if the condition is not extending and progressive, there is the possibility of an immunity to the type of infection set up in the lower respiratory tract. If the necessity for surgery is unquestioned, I am not certain that the type of anesthesia is of paramount importance. The inconclusive nature of the incidence of postoperative pulmonary complications occurring after the use of the various anesthetic drugs may be an argument in support of this indecision. Nevertheless, it is well to avoid irritative agents, to use regional (including intra-spinal) methods where not contraindicated otherwise, and to follow the recognized prophylactic measures against postoperative complications of the lower respiratory tract, such as minimal surgical trauma, avoidance of shock, and the use of the postoperative "stir-up" regime.

Of the acute infections midway between upper and lower respiratory levels, I fear *tracheobronchial bronchitis* to the greatest extent, yet have nothing more specific to offer than in the acute infections of the upper respiratory tract. In diseases of the lower respiratory tract, the outstanding problems include excessive or purulent secretions and the management of proper oxygenation. Excessive secretions should receive the acceptable preoperative treatment of bronchoscopy immediately before surgical intervention (which should not be scheduled in the early morning) and by hearty attempts by the patient to clear the lower tract of secretions. Endotracheal anesthesia, because of the facility of instantaneous and intermittent aspiration, is as near a routine as we find in present day efficient anesthesiologic practices. If sudden and material volumes of secretions may be liberated from a unilateral condition, endobronchial anesthesia may be indicated and life-saving, particularly if the left lung is involved.

The problem of continuous oxygen supply to the alveolar blood stream in diseases of the lower respiratory tract is one of overcoming actual obstruction of the respiratory ducts, or compensating for a decrease in the transfer of oxygen from the alveolar spaces to the adjoining blood channels. The literature is complete, and all concerned should be well informed on this aspect.

Bronchiolar constriction may have been existing preoperatively as bronchial asthma or status asthmaticus, or may develop without warning during induction or maintenance of anesthesia. General anesthesia should be avoided if possible; if not, cyclopropane and pentothal, are not indicated usually. If bronchiolar constriction develops unexpectedly during maintenance of anesthesia with these two drugs, its presence may be suspected by difficult inflation of the lungs, or by delay or increase in duration of the expiratory phase, or both. The addition of moderate quantities of ethyl ether (10 to 30 cubic centimeters) is effective usually in controlling the condition. It may be treated also by intravenous injections of atropine, ephedrine, or procaine. The absorption of ethyl ether is facilitated, too, by the use of these drugs, and coincidental increase in positive pressure during the

inspiratory phase only, by intermittent compression of the breathing bag.

Many anesthesiologists no longer hold to the belief that irritative anesthetic agents, especially ethyl ether, are contraindicated by *pulmonary tuberculosis,* but have no hesitance in using them in chronic forms[16] of that disease.

ENDOCRINE DISTURBANCES

Outstanding among endocrinopathies, because of its numerical incidence is diabetes mellitus. Its aspects with respect to anesthesia are too well known to indicate further consideration here.

Many unexpected deaths in infants and children have been attributed to an enlargement of, or persistence of, the *thymus gland.* The British Committee[16] found that there was no evidence that status lymphaticus exists as a pathologic entity. However, this diagnosis has been used to cover unexpected deaths in patients of younger age groups. It is generally believed that such fatalities have been usually precipitated by technical errors in the administration of anesthesia, especially by anesthetic overdose.

Surgical procedures in the presence of *uncontrolled hyperthyroidism* today are rare. When encountered, they should be managed, from the standpoint of anesthesia, as to whether they are obstructive to respiration, indicating endotracheal methods, or uncontrolled thyrotoxicosis with all its implications, or both.

MISCELLANEOUS

Of the *acute infectious diseases,* certain ones of the exanthematous group call for precautions to avoid all factors which might increase the probability of respiratory complications. Of the *nervous and mental diseases,* surgical procedures in the face of cerebral accidents indicate technics involving as little disturbance of blood pressure as possible, together with inhaled atmospheres rich in oxygen content. Surgery in the presence of *coma* usually requires anesthesia of the skin only. *Myasthenia gravis* contraindicates the use of curare, for in this disease there is interference with the transmission of nerve impulses across the myoneural junction, similar to that in curarized states.[17] Patients with *drug addiction* exhibit marked resistance to anesthetic drugs by inhalation, unless severe debility accompanies the condition. For these patients, regional and spinal technics, are preferable, where not otherwise contraindicated. Premedication should consist of the habitual dose, (if it is an opiate and this can be determined) with the usual preoperative dose superimposed. The symptom of *hypotension* has been of concern in anesthesia. If it is recent and acute, it should be managed as an intermediate stage of shock. If long standing, less concern would probably be aroused. Another important criterion, perhaps, rests in the pulse pressure; for if it is normal, less alarm is indicated; while if it is decreased, more difficulties may be anticipated.

255 Cheswald Lane

16. Pathological Society of Great Britain, *Status Lymphaticus.* Report of Medical Research Council, London, (1926).
17. Beecher, H. K., and Adams, R.: Journal of the American Medical Association, 118:1204, (April 4, 1942).
18. Bennett, A. E., and Cash, P. T.: Archives of Neurology and Psychiatry, 49:537, (April, 1943).

SOCIETY OF SURGEONS

The Society of Surgeons of New Jersey announce their annual meeting in Newark on November 17. Operative and dry clinics will be held at the Newark City Hospital.

The following officers will be installed:

President—Dr. Frank C. McCormack, Englewood.

First Vice-President—Dr. Victor B. Seidler, Montclair.

Secretary—Dr. William H. McCallion, Elizabeth (continued).

Treasurer—Dr. David B. Allman, Atlantic City (continued).

Dr. Royal A. Schaaf, Newark, will retire as president.

Dr. Clarence O'Crowley, Newark, is in charge of arrangements for the annual meeting.

STREPTOMYCIN IN TYPE B HEMOPHILUS INFLUENZAE MENINGITIS*

E. Raymond O'Brian, M.D., Robert T. Shipman, M.D., and
Charles P. DeFuccio, M.D., Jersey City, N. J.

Type B hemophilus influenzae organism is one of the common causes of meningitis in children. In many hospitals, it is reported as the commonest type of meningitis when meningococcic infection is not present in the surrounding community. Before the days of the sulfa drugs, mortality from this disease was almost 100 per cent. With the development of a regime combining the sulfonamides and type B hemophilus influenzae rabbit serum, Alexander [1] could report complete recovery in 78 per cent of her series of 87 cases. Other observers [2] have reported mortality rates ranging from 15 to 50 per cent with this method of treatment. Initial investigation has shown that the type B hemophilus influenzae organism, a gram negative coccobacillus, is markedly sensitive to streptomycin, both in *vivo* and in *vitro*. Reports [3] of the use of streptomycin in meningitis caused by this organism indicate that the mortality can be further reduced.

It is the purpose of this report to record the results of nine consecutive cases of meningitis caused by type B hemophilus influenzae treated with streptomycin at the Jersey City Medical Center.

ADMINISTRATION

Dosage was calculated according to body weight. The intramuscular dose was 20 milligrams per pound of body weight per day, divided into eight equal doses, administered every three hours. The intrathecal dose was 25 to 75 milligrams daily, given as a single dose. The diluent was normal saline, usually 10 cubic centimeters. The exact amount of intrathecal streptomycin was determined by the severity of the infection, which in turn was measured by the clinical manifestations and the concentration of sugar in the original spinal fluid. The appearance of the spinal fluid, the laboratory analysis of the fluid, and the general condition of the patient guided us in deciding when to discontinue the streptomycin.

Sulfadiazine was used in conjunction with the streptomycin in all of our cases. Although streptomycin alone has effected cures in some cases, we do not feel that sulfadiazine should be withheld from these patients on the basis of our present knowledge. The dosage of sulfadiazine was one to three grains per pound of body weight per day, depending on the severity of the disease.

SELECTION OF CASES

All cases reported here showed positive spinal fluid cultures and were identified by type specific antiserum. Several cases with turbid spinal fluid and smears showing organisms resembling the influenzae bacillus were treated successfully, but are not reported here because we failed to identify the organism by culture. During this time two cases of meningitis manifesting mild clinical symptoms were treated with sulfadiazine alone. After the patients recovered, we found that the cultures taken at the height of the disease showed a growth of type B hemophilus influenzae. These cases showed no sequelae or recurrences.

TYPICAL CASE

Chart 1 shows the course and management of a typical case of influenzae meningitis. It is the case of a two year old male, weighing 30 pounds. Eight days before admission he had a pharyngitis and otitis media, with a temperature of 102. He was given a single dose of 200,000 units of penicillin on the third day of this illness and appeared to have made a satisfactory recovery. On the morning of admission, temperature rose to 103 and he became very drowsy. He showed some nuchal

*From the Pediatric Service of the Jersey City Medical Center.

1. Alexander, H. E.: Journal of Pediatrics, 25:517 (December 1944).
2. North, E. A., *et. al.*: Medical Journal of Australia, 1:215 (February 16, 1946), and Paine, T. and Finland, M.: Medical Clinics of North America, 31:1092 (September 1947).
3. Alexander, H. E., *et. al.*: Journal of the American Medical Association, 132:434 (October 1, 1946), and Birmingham, J. R., *et. al.*: Journal of Pediatrics, 29:1 (July 1946), and Nussbaum, S., *et. al.*: Journal of Pediatrics, 29:14 (July 1946), and Weinstein, L.: New England Journal of Medicine, 235:101 (July 25, 1946), and Logan, G. B. and Harrell, W. E.: Proceedings of the Staff Meeting of the Mayo Clinic, 21:393 (October 16, 1946), and Brescia, M. A. and Blaso, W. J.: Archives of Pediatrics, 64:564 (November 1947), and Hoyne, A. L., *et. al.*: Archives of Pediatrics, 65:559 (November 1946).

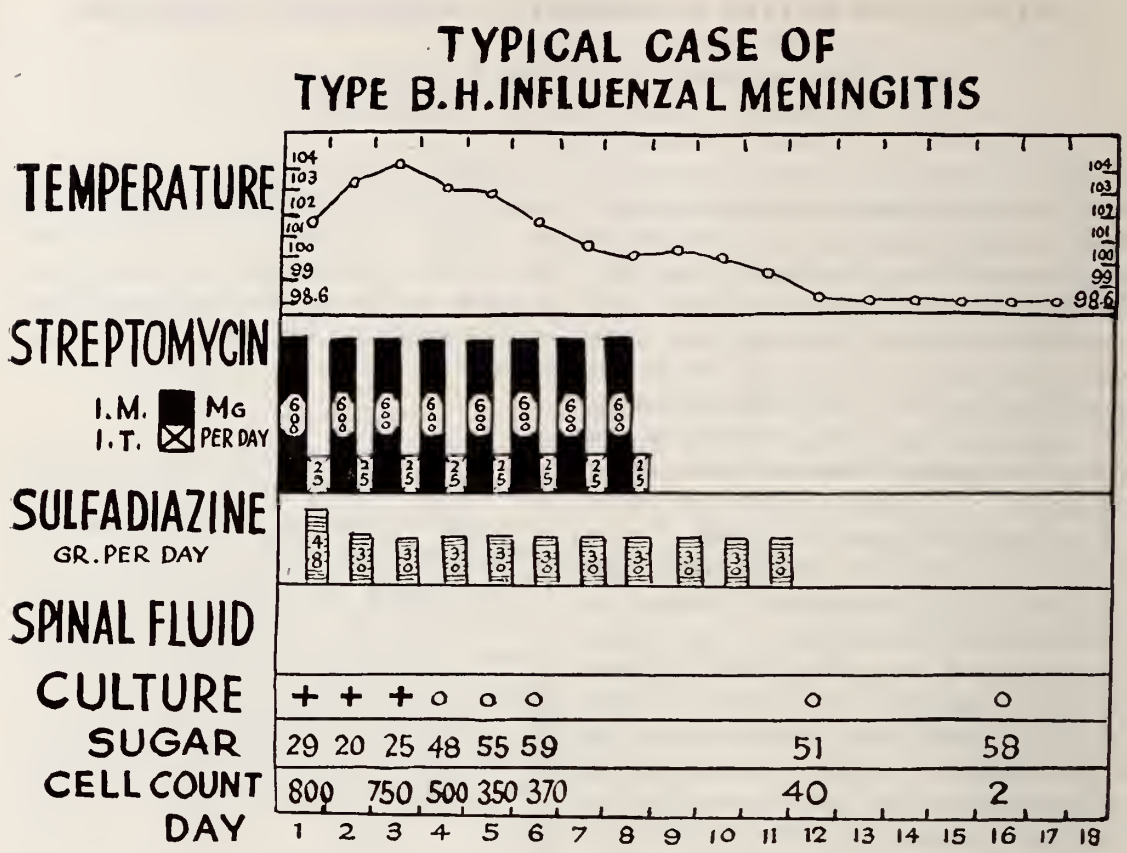


CHART 1

rigidity and a positive Kernig's sign and at this point was admitted to this hospital. The temperature rose to 104 on the third hospital day and returned to normal on the twelfth hospital day. It remained normal until discharge on the eighteenth day. Six hundred milligrams of streptomycin were given daily by the intramuscular route. Seventy-five milligrams were given every three hours and were calculated to deliver twenty milligrams of streptomycin per pound of body weight per day. This was followed for eight days. During the same time, 25 milligrams of streptomycin, diluted in 10 cubic centimeters of normal saline, were given each day by the intrathecal route.

Sulfadiazine was administered daily for the twelve days of febrile course. Forty-eight grains were given on the first day and thirty grains daily thereafter. This delivered one grain per pound of body weight per day. In more severe cases, up to three grains per pound per day were given, in order to increase the therapeutic level of the spinal fluid.

Spinal fluid cultures remained positive for the first three hospital days and were negative thereafter. The original spinal fluid sugar level was 29 milligrams per cent. This dropped to 20 milligrams per cent on the second hospital day. On the fourth hospital day a normal figure was reached and this was sustained thereafter. The cell count, which was originally 800 cells per cubic millimeter, dropped slowly to normal by the sixteenth hospital day. He was discharged on the eighteenth hospital day, and up to the present shows no sequelae.

RESULTS

Nine cases of culture-proved type B hemophilus influenzae meningitis, treated at the Jersey City Medical Center, are shown (Chart 2). Age range was from 7 months to 3 years, with seven of the patients under two years of age. Of the nine cases, seven were males and two were females.

CASES OF TYPE B.H. INFLUENZA MENINGITIS TREATED WITH STREPTOMYCIN

CASE	AGE	SEX	SPINAL FLUID SUGAR	STREPTOMYCIN I.M.-Q3H	STREPTOMYCIN I.T.-DAYS	SULFA DRUGS	SERUM	CULTURE DAYS+	8 NERVE DEAFNESS	RESULT	HOSP. DAYS
1	7Mo.	F	50.5	50Mg X7	25mg X6	+	—	1	O	R	18
2	10Mo.	F	-10	50mg X7	25mg X4	+	—	1	O	R	22
3	2Yrs.	M	29	75mg X8	50mg X7	+	-	3	O	R	18
4	11Mo.	M	-10	50mg X1	50mg X2	+	100mg	1	O	DIED	1
5	14Mo.	M	-10	60mg X6	30mg X6	+	—	1	O	R	64
6	3Yrs.	M	10.8	100mg X8	50mg X8	+	-	2	+	R	16
7	3Yrs.	M	-10	90mg X7	25mg X7	+	—	2	O	R	15
8	16Mo.	M	49.5	125mg X7	75mg X6	+	—	2	+	R	27
9	17Mo.	M	-10	125mg X12	25mg X7	+	—	4	O	R	39

CHART 2

The original spinal fluid sugar levels in milligrams per cent are listed in the fourth column of Chart 2. These show a marked variance, ranging from a high level of 50.5 milligrams per cent to low levels reported as less than 10 milligrams per cent.

In the column headed "streptomycin" it is noted that the intramuscular route was used every three hours for an average period of seven days. Dosage was calculated on a basis of twenty milligrams per pound of body weight over a twenty-four hour period. This was divided into eight doses, administered every three hours. Intrathecal medication consisted of a single daily injection of from 25 to 75 milligrams of streptomycin for an average of six days. Streptomycin was continued in all cases until at least three sterile spinal fluid cultures were obtained.

Sulfadiazine was used in all instances. In most cases it had been used before admission to the hospital. Dosages ranged between one and three grains per pound of body weight per day. In all cases the sodium salt of sulfadiazine (in five per cent solution) was injected subcutaneously for the first few days. This was given every twelve hours in doses calculated to give one to three grains per pound of body weight per day. Two reasons dictated this method of administration: first, we were assured that the total dose which was often rather small in amount was received and held by the patient. Second, many of the patients were unable to take medication by mouth. At the earliest opportune time, depending on the improvement of the disease and the clinical condition of the patient, a switch was made to the oral method of administration.

Type B hemophilus influenzae rabbit serum was given in only one case. This was our only death and we feel that it deserves some explanation. The child had a convulsive disorder for three weeks prior to admission. He had received sulfadiazine at home but had shown no improvement. On admission, the child was markedly opisthotonic and cyanotic. He had a

temperature of 106 and was considered moribund. One hour after admission, the laboratory reported a capsular swelling reaction to type B hemophilus influenzae typing serum, and due to the seriousness of the child's condition, sulfadiazine, streptomycin, and serum were all given. The child, however, after what appeared to be a period of improvement, suddenly expired twenty hours after admission to the hospital. Necropsy showed a profuse, purulent exudate over all parts of the brain and spinal cord. There were extensive polymorphonuclear infiltrations throughout the brain substance. We feel that this patient would not have benefited by any type of therapy and do not feel that the failure of the serum is significant.

In the entire series the spinal fluid cultures remained positive for an average of two days. Eighth nerve deafness occurred in two cases and in both instances it was transitory. Hinshaw [4] recently reported a series of cases of tuberculous meningitis treated with streptomycin for several months. He concluded that under the age of thirty years, permanent nerve deafness from streptomycin was uncommon, and that in children permanent deafness was extremely rare.

All of the patients presented here, except for the one death, recovered with no known sequelae. Average hospital stay was twenty days. One was hospitalized for sixty-four days because of a persistent elevation of lymphocytes in the spinal fluid. This gradually returned to normal, and the child showed no evidence of any localized process. We have not been able satisfactorily to explain this finding.

SUMMARY

Nine cases of type B hemophilus influenzae meningitis treated with sulfadiazine and streptomycin are presented. All cases were in children under three years of age. Eight of the nine cases recovered, giving a mortality of 11 per cent.

CONCLUSIONS

(1) A combination of streptomycin and sulfadiazine constitutes adequate therapy in the mild and moderate cases of type B hemophilus influenzae meningitis.

(2) Streptomycin and sulfadiazine in type B hemophilus influenzae meningitis have considerably reduced our mortality rate for this disease.

(3) In severe cases and in patients who do not respond to this therapy, type specific rabbit serum should also be used.

12 Duncan Avenue

4. Hinshaw, H. C.: From a paper read at the Annual Meeting of the New York Academy of Medicine (January 7, 1948).

CONTROL OF MUSCLE SPASM AND ARTHRITIC PAIN

The striking and dramatic relief of painful muscle spasm and arthritis pain through anesthetization of the sympathetic at the nasal (sphenopalatine) ganglion is recommended by Ruskin * as a new and effective approach to the treatment of arthritis. He visualizes an intimate relationship between muscle metabolism and spastic states with impaired peripheral circulation and joint nutrition. Edema of the small and large joints rapidly disappeared after the relief of muscle spasm, and mobility of the joints could be obtained within a few minutes. A muscle in the contracted or spastic state has spent its energy; relaxation is the phase that requires energy similar to that of a rubber band which requires a pull for elongation. The contracted state represents the expenditure of energy. For the restoration of energy for relaxation the adenylic nucleotides as the iron salt, (ironyl) is employed. Since all muscle energy is obtained through the breakdown of the system adenylic acid—adenosine diphosphate— adenosine triphosphate (ATP), the immediate supply of the adenylic nucleotide (ironyl) served as a "booster" for muscle relaxation. The treatment of the sympathetic apparently musters reserve energy to start the relaxation while the adenylic nucleotide supplies the additional fuel for its continuation.

Sixty-eight cases of striking relief are cited.

* Ruskin, S. L.: American Journal of Digestive Diseases, 13:311 (October 1947).

THE MECHANICS OF GASTRO-INTESTINAL ROENTGENOLOGY

George H. Stein, M.D., and Manfred Kraemer, M.D., Newark, N. J.

Many private practitioners now have, or expect to install a fluoroscope. Others have x-ray equipment and more hope to in the near future. This interest in roentgenology has developed not only because the physician regards it as an invaluable aid in diagnosis, but, also because of public demand for x-ray examinations. The average patient regards the x-ray somewhat like an adding machine—a few buttons are manipulated and out comes the correct diagnosis. The public must acquire a better understanding of the value and limitations of x-ray. The physician on the other hand, must realize that roentgenology of the digestive tract is an art which requires study, care, effort and a well organized flexible routine. Only those willing to qualify themselves by long study and practice should attempt radiologic procedures. In taking films of the gastro-intestinal tract, the examiner must be painstaking and unhurried. If roentgen technic is pursued in a rushed disorganized and unintelligent manner, the procedure and the profession fall into disrepute.

Fluoroscopy and x-ray films constitute the modern physical examination of the gastro-intestinal tract. Inspection, palpation, auscultation and percussion are of diminishing importance. It is the purpose of this paper to help the physician get the most out of his equipment and to lead to a better understanding of this method, its limits and hazards.

ASSISTANTS

An assistant, nurse or technician is helpful though not essential. Neither the taking nor reading of films should be delegated to non-medical personnel. Within a few months an intelligent nurse can be taught to be a helpful assistant. We prefer a trained nurse to a trained technician when only one assistant is needed in the x-ray room.

EQUIPMENT

In choosing a fluoroscope, insist that it be shock-proof with the newest fluoroscopic screen for better definition and enough power to reveal adequately the abdomen of a 200 pound patient. Anything less powerful is unsatisfactory. Any screen purchased more than a year ago should be replaced by the newly improved fluoroscopic screen made available early in 1948. For gastro-intestinal radiology, a 200 milliampere shock-proof apparatus with a movable Bucky diaphragm are essential. If expense is no object, there are 200-500 milliampere machines, with rotating anode tubes and electronic devices for producing radiographs of consistent excellence. Do not be talked into buying a 100 milliampere machine. We have tried them and found that they cannot take satisfactory gastro-intestinal films. The x-ray table should be of the "tilt" type allowing for vertical and horizontal fluoroscopy as well as radiography. The table may be raised manually. A motor driven table is not essential, representing only extra cost for added convenience. It is better to have two x-ray tubes, one over the table and one under the table; this allows rapid horizontal fluoroscopy without the extra time needed to bring the over table tube to its position below the table. These extra features can all be sacrificed if there is plenty of time and excellent radiographs can be made without them if one has a 200 milliampere machine.

The servicing of x-ray equipment is an important factor and systematic, prompt service by the company is a definite advantage in selecting an x-ray machine. Do not buy a machine unless there is a service man *employed by the manufacturer* available at all times. Services rendered by "agents" are often inadequate. We have kept our plant working for 12 years without missing a day by adherence to the policy of purchasing equipment from a manufacturer who employs full-time factory trained service men in Newark.

Ventilation of the x-ray room is important. Prior to installation of our present complete air conditioning system we did well with a second

hand light proof blower which circulated 1000 cubic feet of air per minute and was purchased and installed at a pre-war cost of $100. Light proof blowers can be purchased ready made and installed in the wall to permit circulation of air.

There is a tendency to have the x-ray room and dark room too small. It is best to double the minimum recommended space for the x-ray room and quadruple the minimum recommended space for a dark room.

SPOT DEVICES

Spot radiography has been a great advance in the more accurate diagnosis of gastro-intestinal disease. During fluoroscopy when the operator sees a lesion or a suspicious shadow, nothing is more gratifying than to film the area in a matter of seconds. See it—film it! Many radiologists and gastro-enterologists do not have a spot device. Good ones are expensive and months of practice are required for their proper use. But when properly applied and mastered they often make the difference between a correct and an incorrect diagnosis. Particularly is this true in lesions of the duodenal bulb, posterior wall ulcers high in the stomach, small bowel disease and in other areas where the lesion is small, non-constricting and easily hidden by over-lapping structures or excessive contrast medium.

THE DARK ROOM

The processing of films is an important feature of good x-ray technic. The developing tanks should not be too small and the solution should be kept at the proper temperature. Simplified developing charts are available from the film manufacturers. A dryer is necessary if more than one patient is filmed each day. The larger the dark room, the more efficient the processing becomes. A fairly large dark room will allow for shelves, cabinets, dryers, air conditioning unit and miscellaneous storage for x-ray film, envelopes and accessories. A practitioner who is meticulous about his dark room is usually one who is meticulous in the technic of positioning and filming in the x-ray room. Smoking should not be permitted in the dark room and the room should be swept and cleaned at the end of the day's work allowing twelve hours for dust to settle before any films are exposed. A disorderly dark room is the mark of the sloppy worker. Position the patient properly, take the film properly, process the film properly and you have all the preliminary elements of a correct diagnosis.

HAZARDS AND SAFETY FACTORS

Anyone who regards exposure to x-radiation lightly is a fool. Many pioneers have paid heavily for ignorance of x-ray effects. Today with our extensive knowledge of the hazards of x-ray exposure, there is no excuse for negligence, carelessness or indifference. Technician and physician should take every precaution to avoid the harmful effects of x-radiation.

What are the harmful effects? The incidence of leukemia is higher in radiologists than in the general medical population. Excessive exposure may result in skin changes, blood changes, glandular and skeletal effects and fetal deformities. The genetic and sterility effects of x-ray exposure are important to the individual and eventually to the human race.

The quantity of x-radiation may be measured. There are several devices on the market which will inform the physician from day to day whether he is exceeding the tolerance dose. The maximum tolerance dose should not exceed 0.05 roentgens for a 24 hour period though some writers consider 0.1 roentgen a safe daily dose. Crowding many patients in the fluoroscopic room on one day so that the physician may be at leisure the next morning is not a healthy routine. You must know exactly how much exposure you are getting and the only way to determine that is to purchase or borrow a scientific measuring device.

We use the "Victoreen Minometer" to measure stray radiation in our x-ray and fluoroscopic room. The instrument consists essentially of a string electrometer and an ionization chamber. The electrometer is calibrated to a known voltage which is read on the scale in roentgens. The chamber acts as a condenser which (when inserted in the electrometer) is charged to a definite voltage. The chamber looks like a fountain pen and has a clip which can be pinned across the physician's tie or the technician's collar. The chamber must be worn above the lead apron so that it is exposed to stray radiations. The radiation ionizes the air within the chamber and causes the voltage to leak off. When the chamber at the end of the day is re-

inserted into the electrometer, the voltage change is indicated on a scale in roentgens. Since the maximum tolerance dose per 24 hours is 0.05 roentgens, any amount exceeding this should call for lessened fluoroscopy and a check on the equipment and safety factors in the x-ray room. We have not exceeded the 0.05 roentgen per day and our daily average is about 0.03 roentgen for a busy morning's schedule. If the equipment has been checked and all the recommended safety factors are in use, there should be no difficulty in maintaining this figure. The chamber may be purchased separately. The entire apparatus costs about $160 and individual chambers cost $12.50 each. The physician may purchase a chamber and use the electrometer of a nearby radiologist or hospital; thus for an investment of $12.50, he eliminates any risk of over-exposure. We know of no better insurance for "x-ray health" than the proper use of this equipment.

Lead gloves and a lead apron are imperative in the fluoroscopic room. The physician should accommodate his eyes thoroughly before fluoroscopy. This will allow him to fluoroscope at low milamperage and kilovoltage, which is an added safety factor. A minimum of twenty minutes use of dark adaption goggles is essential before starting fluoroscopy. We use the new polaroid goggles which can be worn over eye glasses and enable the wearer to carry on his work during the period required for accommodation. Their only disadvantage is that objects colored red (and red print) are rendered invisible. These glasses may be purchased for a few dollars and should be worn constantly during that part of the day in which fluoroscopy is being performed. We have seen physicians walk directly from their consulting rooms into the fluoroscopy room without an attempt at accommodation of the eyes. Such a practice is a fraud.

It has been suggested that personnel using x-ray equipment have blood counts every three months. It is the responsibility of the physician to protect himself, his patient and his technicians, using every means to accomplish that purpose.

PREPARATION OF THE PATIENT

An improperly prepared patient predisposes to inaccurate interpretation of the x-ray film. In fluoroscopy of the upper gastro-intestinal tract the patient should abstain from food for at least eight hours prior to the examination. Food may be taken up until 10 p. m. of the evening preceding the x-ray examination. Stomachs that are obstructed need preliminary gastric lavage. We routinely introduce a Levine tube previous to every radiologic examination to make sure that the stomach is empty. This simple procedure can be performed without difficulty and assures a clear stomach for barium examination. For barium enema examination, two cleansing soap suds enemas are prescribed for the previous evening, one after the evening meal and one at bedtime. Do *not* order cleansing enema an hour or two before filming. This results in retention of fluid with subsequent dilution of barium and imperfect films. Never use a laxative by mouth in preparing patients for examination.

PREPARATION OF THE CONTRAST MEDIUM

An electric mixing device is helpful in preparing a smooth homogenous barium water mixture. We use a Hamilton Beach malted milk mixer as used at soda fountains. Lumps of barium will produce confusing shadows. If barium and water are mixed by hand be sure to dissipate all lumps. A good routine is to prepare half a glass of a thick mixture of the consistency of a very heavy cream and one glass of a thin mixture of the consistency of top milk. The heavier mixture is used for mucosal study and small bowel roentgenology. The lighter mixture is used to fill the stomach. For the barium enema examination a lighter mixture is also used. The addition of other substances (acacia, chocolate syrup, tannic acid) is not necessary and often causes confusing patterns. Barium is tasteless and the patient who fusses because of its disagreeable nature is undisciplined and will fuss just as much regardless of what is added for flavoring. For the physician who examines one or more patients a day we recommend the 100 pound carton of barium sulfate, as the saving is considerable. Be sure to keep the barium container covered at all times to exclude foreign matter. Patients resent the presence of dust particles or lint.

METHOD OF EXAMINATION

The patient is placed behind the fluoroscopic screen facing the examiner in the erect posi-

tion, holding the half glass of the thick barium mixture in the left hand. The examiner is seated in front of the screen wearing lead apron and lead gloves. It is advisable to wear a pair of thin white cotton gloves within the lead gloves. These absorb perspiration and prevent deterioration of the inner lining of the lead gloves. The chest is surveyed before any barium is swallowed. The lung fields can be quickly scrutinized for any change in illumination or any suspicious shadows. The subject is directed to inhale deeply and the movements and levels of the diaphragm are observed. The patient is instructed to cough and the apical illumination is considered. The heart is then viewed; first, its general size and configuration and then its borders. Any abnormal pulsation is noted. The patient is now rotated counter clockwise slowly so as to bring the right side toward the examiner (right oblique position)* and to make clearly visible the posterior mediastinum. Any abnormality of the retro-cardiac space is observed. Now with the fluoroscopic screen at the neck level, the patient is directed to take one small swallow of the barium mixture. This first swallow is important and the barium should be followed by quickly moving the screen downward from the mouth to the stomach. Small esophageal diverticula, abnormalities of the pharynx and esophageal varices and obstructions may thus be demonstrated. If some esophageal abnormality is found do not now waste time studying it. Follow the barium to the stomach. Posterior wall ulcers and those high on the gastric curvatures may be visible only at this time but are frequently obscured and missed when additional barium is swallowed or while time is wasted in studying the pharynx or esophagus. If you see any suspicious area in the stomach with the "single barium swallow", spot films should be made at the most favorable angles. If you do not have a spot device, the fluoroscopy should be discontinued until films are taken at favorable angles. Fluoroscopy can then be resumed. The patient is directed to take additional swallows of the barium and the examiner has another opportunity to observe the esophageal outlines and the cardio-esophageal region at his leisure. Films of the esophagus can be taken at this time. As the barium is traversing the lower end of the esophagus, the patient is directed to inhale deeply; this illuminates the retro-cardiac space and brings into clear view, the lower end of the thoracic portion and the abdominal portion of the esophagus. By pressing on the epigastrium with the gloved right hand while the patient is swallowing, barium can (especially in thin people) be held temporarily in the upper part of the stomach. The cardiac end of the stomach can thus be studied for changes in density, deformity of the gas bubble or irregularity of contour. By releasing pressure slowly (if too much barium has not been swallowed) the gastric rugae are now brought into relief by the palpating gloved hand. Carefully displace the barium by pressure and study the rugal folds. The patient is slowly turned during the procedure, for greater accuracy in identifying any lesion. Any suspicious shadow should be checked, either with the spot device or by the taking of films. The patient now has half a glass of the thick barium mixture in the stomach. The prepyloric region and the duodenum are ready to be examined. The prepyloric region is ironed out with the glove protected palpating hand and any irregularity is noted. Many times the duodenal bulb will fill at this time and it should be studied for any change of its normal contours or differences in density. Before films of the bulb are taken, be sure that active peristalsis has started and that the barium is traversing the duodenal loop. If peristalsis is slow to start have the patient wait five to ten minutes. Inadequate duodenal filling (often interpreted as "spasm") is not due to any disease of the subject but is evidence of the examiner's impatience. Spot films or regular films of the bulb may then be made in the projection outlines below.

The first oblique projection is obtained by slowly turning the patient counter clockwise. This is the *right* anterior oblique position, the right side of the patient being nearest the film or screen.

The second oblique is the *left* anterior oblique, with the left side of the patient nearest

*The side nearest the fluoroscopic screen or x-ray plate is used to designate the oblique or lateral position, i.e. right oblique means the right side is nearest the screen or plate.

the film. The patient is turned clockwise to obtain this view. In turning the patient, make sure that the duodenal bulb is not overlapped by small bowel loops or by the stomach itself. In very thin individuals part of the spine will overlap the bulb but this is not a hindrance with adequate equipment. The duodenal bulb of the average patient will be easily identified and cleared of overlapping structures by either of oblique positions. Stocky and heavy subjects and those patients having the bulb in a posterior position will have to be placed in a right anterior lateral position to uncoil the duodenum and to bring it into its proper relationship. Films of the duodenum with the cap obscured by overlapping of stomach or duodenum are evidence of inexperience or incompetence. The seemingly spastic duodenal bulb is a problem. This is best handled by discontinuing fluoroscopy and having the patient wait 15 minutes. Usually this will allow the necessary relaxation of the bulb and satisfactory films may then be obtained. After the bulb has been studied, observe the duodenal loop. Keep in mind that post-bulbar ulcers are becoming more frequently recognized due to more careful fluoroscopy and study of the post-bulbar area on films. The entire duodenal loop is an important region for fluoroscopic scrutiny, especially in cases with otherwise negative findings. Diverticula are often noted in distal portions of the loop and slight irregularities might be evidence of pancreatic disease. We consider the following projections as minimal for a satisfactory survey of the stomach and duodenal loop:

(a) Two right anterior oblique views, in different degrees of obliquity depending on the body type of the patient. The thinner the patient the less the degree of obliquity.

(b) A prone Trendelenberg view after the patient has taken the additional glass of thin barium mixture. This is made with the patient in the prone position, lowering the head of the table and moving and angling the tube to parallel the table so that the primary beam will still intersect the center of the casette.

(c) An oblique view after the patient has taken the glass of thin barium mixture.

(d) A right lateral projection in stout individuals. This is of especial importance in observing the descending portion of the duodenum and in studying the duodenal contours for post-bulbar ulcers, diverticula, infiltrations and anomalies.

(e) Other views of less importance include the erect, supine and left oblique projections. These views do not have to be made in the average case; although in the unusual case, they are of decided value.

If the stomach and duodenal films are technically satisfactory the next film will be taken in one hour. At this time, the degree of gastric emptying and some of the small bowel pattern are observed. The average case will require a film at one hour or two hours. At either time the barium is well along the small bowel pathway. If the stomach has not emptied by the time the last film is taken, the patient is told not to eat for two hours, (since it is not advisable for food and barium to mix) if a barium enema examination is to be performed the next day. Some radiologists and gastro-enterologists take five or six hour films to note whether the stomach is completely empty and also to visualize the ileum. We have abandoned this as a routine procedure.

SMALL BOWEL STUDIES

If the small bowel is suspected as the site of disease, and also in all cases of diarrhea, a small bowel study is made in the following fashion. The patient comes in at 8 a. m. on an empty stomach and with half a glass of thick barium mixture, the esophagus, stomach and duodenal bulb are carefully fluoroscoped and films are taken as outlined above. Films are then taken every hour until the stomach is completely empty. Interval fluoroscopy is made as needed. When the stomach is empty the patient is directed to have a light lunch and to return to the office in one hour for further films. At this time, we fluoroscope the patient and observe the jejunal and ileal loops. Films are taken every hour until the head of the barium meal is in the colon and the tail is in the terminal ileum. Final fluoroscopy is now made, rotating the patient until the best visualization of the terminal ileum is obtained. The optimum position is noted and films are made of the terminal ileum, the ileo-cecal junction and cecum. It is occasionally necessary to take films as late as 11 p. m. (fifteen hours after barium ingestion) in order to obtain satisfactory views of the terminal ileum.

A special view which we have found helpful in separating the ileum from the cecum (and thereby demonstrating the actual ileo-cecal junction) is the "right buttock anterior supine, oblique". The patient lies on the back and with the chest and shoulders firmly on the table, the pelvis is rotated to the patient's right i. e. right buttock against the plate. An 11 x 14 or 14 x 17 film is used and if the iliac crest is two inches below the cephalad portion of the casette, the area involved is very nicely demonstrated.

BARIUM ENEMA EXAMINATION

This examination is usually made in the morning. Two cleansing enemata the night prior to coming to the office are advisable: one enema after dinner and one before retiring. Give the patient written or printed enema directions. A copy of our direction card follows:

"The enema should consist of a quart of warm water with a teaspoonful of bicarbonate of soda added. The quart of warm water can be measured in a quart milk bottle. Dissolve the bicarbonate of soda in the quart of water and pour it into the enema bag or can. Hang the bag or can in the bathroom about the height of the head. Put a little vaseline on the tip of the enema tube. Lie down on your back on the floor and insert the tip of the tube into the rectum. Then let the enema flow in very slowly. After all has gone in, remove the tip. Remain on your back three to five minutes and then expel the enema into the toilet."

Cathartics are contraindicated since they produce colonic irritability and spasm. The barium enema apparatus consists of a stainless steel enema can with a handle, rubber tubing, a metal clamp for starting and stopping the flow, a bulb syringe midway between the enema can and the plastic rectal tip, for the purpose of manually pumping the barium through the rubber circuit and a plastic disposable rectal tip developed by us which is discarded after each examination. The patient is told beforehand the details of the procedure with the room still light in order to obtain maximum cooperation. He is assured that the enema will be seen and that the bowel will not be overfilled so that he will be able to hold all that is given him. The patient is told that he will be given a chance to go to the toilet as soon as films have been taken. In patients with highly irritable colons or relaxed sphincters barium may be expelled onto the table several times before satisfactory filling is obtained. We always have large moist sponges, a sponge mop and a basin in case of accident. Patient's gowns and sheets are kept well up above the buttocks during the examination to avoid soiling. The well-lubricated enema tip is gently inserted through the anus before the room is darkened using utmost care not to hurt the patient and lose his cooperation. The colon is visualized fluoroscopically and the recto-sigmoid, both flexures, the cecum and terminal ileum are carefully scrutinized as the patient is turned from side to side to unfold the loops. No barium enema examination can be considered complete unless the sigmoid and both flexures are thoroughly uncoiled and examined. The carcinoma of the colon that is missed is usually the one hidden in the sigmoid, the flexures or cecum. It is imperative that these regions be carefully explored before a negative diagnosis is made. While the enema is being introduced the assistant should constantly be certain that the enema tip is within the rectum. She does this by protecting the tip with her right gloved hand as the operator assists and directs the patient in turning from side to side. With her left hand the assistant regulates the speed of flow of the enema. After the entire colon is filled fluoroscopically, the terminal ileum is filled by retrograde palpation whenever possible. Films are then taken in the postero-anterior, right anterior oblique and lateral position. Speed is important in taking these films as the patient is struggling to hold a colon full of barium. As soon as the films are taken the patient is directed to go to the toilet and expell as much barium as possible. The patient then returns to the x-ray room for post-evacuation films.

Air contrast studies are occasionally advisable. The apparatus necessary is a double bulb rubber insufflater and tubing ending in a plastic tip. Under fluoroscopic control, air is injected into the colon after the patient had previously evacuated the barium. Strong pressure should never be used. In patients with diverticula and in the aged and infirm it is best to omit the procedure as there is danger of colonic perforation. After the air has been in-

jected, films are taken and then the patient is directed to the toilet to expel as much air as possible. Caution the patient from "straining" in the bathroom. The spot film device may be used to demonstrate colonic lesions during fluoroscopy.

GALL BLADDER EXAMINATION

As a routine we start our roentgen examination of every patient with a cholecystogram. We take our gall bladder films at 8:00 a. m. and after a satisfactory view is obtained, gastric analysis is performed. This lasts from about 8:30 until 9:30. After the stomach is completely emptied through the gastric tube we do the barium examination of the stomach. Next day, the barium enema examination is made and if the gall bladder films were unsatisfactory a second dose of dye is given and the cholecystogram is repeated on the morning of the barium enema. Thus a cholecystogram, gastric analysis and gastro-intestinal x-ray series including barium enema can be completed on two successive mornings. We cannot understand why such a technic is not in general use as it saves much valuable time. Twenty-four and forty-eight hour films are of no clinical significance. These procedures are as significant to a gastro-intestinal examination as listening to both apex and base of the heart are to a cardiac examination. A "dyspeptic" who fails to have a cholecystogram made because of atypical symptoms is as badly off as the patient whose doctor examines only the eye that seems to bother him and omits the other eye.

On the night prior to the gall bladder examination, the patient is given "priodax" tablets, one tablet for every 25 pounds of body weight. The following printed instruction card is given the patient.

This dye is absorbed from the digestive tract and stored and concentrated in the gall bladder, enabling us to obtain an x-ray picture of the gall bladder. In order to insure proper absorption and concentration, and to prevent the gall bladder from emptying before the picture is taken these directions must be followed exactly.

1. Eat your evening meal as outlined below *promptly* at 6:00 p. m.

2 For your evening meal choose from the following: Tea or coffee with sugar but without milk or cream; fruits, cooked, raw or juiced; bread or toast, with jelly but without butter; boiled or baked potato with salt. Omit all other foods including butter, milk, cream gravies and dressings.

3. With the evening meal and continuing afterward, take one priodax tablet with a sip of water every five minutes. Take all the tablets given to you.

4. After the last tablet has been taken, eat and drink *nothing*. Report to the office at 8:00 a. m. in the morning with an empty stomach.

5. Take no laxative or enema and no other medication. If the tablets cause cramping, diarrhea or burning on urination do not become alarmed.

6. If any question arises call the doctor.

If there has been vomiting or diarrhea the gall bladder may not visualize or visualizes faintly, though despite both, enough dye is usually obtained to get good visualization. Repeat the priodax administration the next night if the gall bladder fails to visualize or shows up faintly. Question the patient as to whether he actually swallowed the dye tablets, since occasionally, you run into a patient with a low intelligence, chronic forgetfulness, or plain "orneriness" who fails to do so. Films are made in postero-anterior, oblique and supine positions. A view which is often neglected in gall bladder roentgenology is the erect view. This view is of importance to diagnose papillomata and radio-lucent gall stones which enter into layer formation. If there is any "gas" over-lying the gall bladder, a cleansing enema should be given. If this is ineffectual, an ampule of prostigmin 1-2000 is administered if there is no contraindication to its use. The cleansing enemata and occasional use of prostigmin will clear the right upper quadrant of confusing and overlapping shadows and reveal a clear view of the gall bladder. Unless this is done in a meticulous manner, false positive conclusions are sure to be reached. Having obtained clear views of the gall bladder, you decide whether to give a fatty meal to consider gall bladder contractility. If the gall bladder is well visualized and the concentration is excellent the fatty meal is not given. However, if there are suspicious densities within the gall bladder shadow, the fatty meal examination may furnish important information. Persistent non-visualization of the gall bladder, when technical errors have been ruled out, is of pathologic significance. Fluoroscopic examination of the gall bladder is unsatisfactory and the procedure should be attempted only by those who have x-ray apparatus.

234 Roseville Avenue

DIAGNOSTIC BOOBY TRAPS*

Hilton S. Read, M.D., Atlantic City, N. J.

Dr. David Riesman was authority for the statement that one's positiveness in diagnosis is in inverse proportion to one's experience. If increased girth and decreased hair are the outward manifestations of anxiety, then the twenty-fifth year after graduation from medical school would seem to be the peak of diagnostic doubt. This is then, an appropriate time to consider diagnostic booby traps. In this category, top vexing priority must be awarded to—

1—Psychoneurosis. This old medical commodity, recently repackaged and relabeled is now being spot-lighted in city and hamlet alike.

2—The menopause-anxiety duo.

3—That tantalizing trio: syphilis-diabetes-allergy.

4—Carcinoma of the lung.

As for psychoneurosis, even the popular magazines are now featuring psychosomatics. As it appeared in a recent issue of *The New Yorker*—

It's psychosomatic, now psychosomatic.
You fell down the stairway? It's psychosomatic
The sprain of the ankle while waxing the floors
You did it on purpose to get out of chores
Nephritis? Neuritis? A case of the ague
You're just giving in to frustrations that plague you.
You long to be coddled, beloved, acclaimed,
So you caught the sniffles—and ain't you ashamed!
And maybe they're right; but I sob through my wheezes
"They've taken the fun out of having diseases"[1]

LESSON ONE

A forty-six year old white female was first seen by us on August 25, 1947, with the following complaints: Pain in epigastrium, under the ribs, high in the left quadrant and girdle-like, gas, indigestion, insomnia, anxiety, tension, anorexia, fatigue, mild constipation, menstrual irregularity.

She had been receiving estrogenic substance twice a week for six weeks. She was the spoiled only child of indulgent, elderly, wealthy parents. Her first marriage to a modern Casanova resulted in two sons, unwanted by the father, who bought himself an extramarital urethritis, so that the patient developed a fear of and refused intercourse. Divorce ensued. The second marriage was to a neurotic salesman of limited income. It is axiomatic that neurotics marry neurotics. Wife number 1, an alcoholic, visited them on their marriage night. The eighty year old mother-in-law lived with them or demanded a daily letter from the patient's husband. Formerly accustomed to a $6000 a year household budget, she was reduced to $125 a month for everything, including the operation of the family car. Vacation visits of the husband's ten year old son by his first marriage were the signal for battles over whether the allowance for his keep should be $1 a day or $5 a week. In other words, as fine an omelet of psychosomatic eggs as you could hope to unscramble.

Her ptosed colon, which was otherwise normal by barium enema, was not used to explain her constipation. Her story, plus roentgenologic evidence of a duodenal diverticulum that emptied promptly and was not tender on pressure under the fluoroscopic screen, prompted us to convince first ourselves and then her, that the pain was the somatization of anxiety.

Eight months later we received the following, which is an excerpt from a letter from her family physician:

"She was taken with sudden excruciating abdominal pain while housecleaning on April 22, and died the next day of a perforated carcinoma of the splenic flexure."

THE MENOPAUSE

The menopause has, in our experience, too often been accepted by patient and physician alike as a two to ten year moratorium for any

* From a clinic given June 2, 1948, by Dr. Read at the Jefferson Hospital in Philadelphia, as part of the celebration of the silver anniversary of the class of 1923 of the Jefferson Medical College.

1. This is the last verse of a poem by Phyllis McGinley published in the February 28, 1948, *The New Yorker* and quoted here by permission. (Copyright, *The New Yorker* Magazine, Inc., 1948). Dr. Read actually delivered the entire poem —five more stanzas like this, but as I intend to quote it in full myself some time, only the terminal verse is here used.—Editor.

and all symptoms and signs in females aged twenty-five to sixty-five. More often than not, it is intellectual cowardice on our part that keeps up from orienting the patient on her true dilemma: anxiety,—anxiety over losing her mind as her neighbor did; anxiety over the passes her husband now makes at girls that do not wear glasses; and anxiety over the loss of center stage to her prep school sons.

THE TANTALIZING TRIO

Heaven help the patient who demonstrates a positive Mazzini or glycosuria or a positive skin test, particularly if he has sneezed six times in six months. Once hung on the luetic-diabetic or allergic diagnostic hook, he has practically to rot off with another unrecognized illness to jar us out of our diagnostic smugness.

Carcinoma of the lung, in its own right, is sufficiently perplexing to grey our hair, but compounded by one of the tantalizing trio, the patient has even less chance of an early diagnosis.

From March 1946, until January 1948, we saw and/or recognized one chest tumor, proved at operation as a lipoma from the posterior mediastinum. From January 1948 to March 1948, we saw and/or recognized ten bronchogenic carcinoma. Time is not available to explore the inadvertent bias of these statistics. Three patients may illustrate the internist's responsibility in this disease, which frequently booby traps us.

1. A fifty-three year old, two hundred eighty-one pound blacksmith, was first seen March 4, 1948. He was referred by his wife's gynecologist for possible gallbladder disease, because of upper right quadrant pain and the history of having gained eighty pounds in the past two years—(forty in the past month). Three weeks prior to being seen, he started with severe epigastric and precordial pain. Two weeks later it shifted into his back, with radiation anteriorly more or less along the course of the ureter. Hypodermic medication was required two nights before we saw him. Our working diagnosis was radiculitis. X-ray of the vertebrae was negative. Routine chest films showed "an area of fairly homogenous density with indefinite infiltrating margins extending down the right diaphragmatic dome and occupying the medial portion of the lower right lung field". He was hospitalized March 8, because of severe pain. On March 16, he developed a sensory deficit and a flacid paralysis of the legs and bladder. On March 19, he died, with a complete paralysis below the tenth thoracic. A limited postmortem showed a bronchogenic carcinoma of the right lung.

2. A sixty-four year old printer, was treated by me fifteen years ago for diabetes. A portable x-ray done elsewhere on February 27, 1947, for cough, was reported as negative. Recently, he had been consulting a physician friend for severe pain in the right scapular region. He was seen by one of us on February 11. X-ray of the thoracic vertebrae the next day gave the clue. A chest film gave the answer: "There is a large tumor mass, measuring 9 centimeters in its greatest transverse and 11½ centimeters in its greatest vertical diameter, occupying the posterior portion of the right upper lobe." He was referred to a thoracic surgeon and stayed a day or so at the hospital, when he packed up and left unceremoniously. He is now fairly comfortable under x-ray and teropteron therapy.

3. A retired merchant, 69 years old, was seen at the Ventnor Clinic, on October 27, with a severe cough. X-ray of the chest was reported as "atypical pneumonia, right lower lobe. If there is any question clinically of the diagnosis of pneumonia, advise further appropriate roentgen studies to rule out neoplasm." He was at the Atlantic City Hospital from October 28 until November 8, 1947, and discharged to his winter home in Florida. Enroute to Florida, he started to spit blood and was twice hospitalized there for bronchoscopy, which was understandably reported as negative. He returned to us on February 27, 1948, showing a loss of ten pounds in weight, bilateral paralysis of his vocal cords, and an homogenous density in the left upper lobe of his chest roentgenogram. A tracheotomy was done the next day. The tumor was found to have invaded the mediastinum and ribs when explored. He has had remarkable relief from pain on teropteron.

The internist's responsibility in carcinoma of the lung is a significant one. Primarily, it is to think of it as a diagnostic possibility. But in addition, he *must* require "check films" in aging individuals convalescent from viroid pneumonia. In suspicious patients, he must request auxiliary aids such as bronschoscopy with lavage, after the method of Herbut and Clerf.

Heublein, of Hartford, asserts that, stated in percentages, urinalysis "pays off" in something to the right of the decimal point, routine blood counts 3 per cent and routine chest x-ray 10 per cent. The internist should encourage the development of economic technics that will permit the inclusion of routine inspiratory and expiratory chest films in the annual physical inventory.

5407 Atlantic Avenue

HYSTERECTOMY *

A SURVEY OF TWO THOUSAND OPERATIONS

ALBERT S. HARDEN, M.D., Newark, N. J.

In bringing to your attention a survey of this scope, I do so with the idea not of destructive criticism, but, to make a plea for a more conservative approach to the removal of the uterus during the child-bearing period. The assistance that now may be gained through the use of the laboratory in the determination of the cause of uterine bleeding by either "quicky" curettings or by the vaginal smear, would, in an appreciable number of instances in this series, have saved this important female organ.

To correlate over a period of 18 months a survey of 2065 cases, some assistance is needed; in this case we had the hearty cooperation of both the historians and pathologists of the six hospitals from which the data were obtained and to them I express my deepest appreciation. Thanks are also due to the management of the hospitals for their permission in extending me the privilege and I assure them that I have not individualized any one hospital nor the surgeons connected thereto.

This survey was instigated by the papers of Miller and others as well as by the seemingly large numbers of hysterectomies being performed in our vicinity. I am pleased to state that our statistics as to errors in judgment are very much better than theirs. However, there is room for improvement. This is especially true in pre-operative treatment and indications. As to histories, the less said the better. I have formulated a chart which has now been adopted by one of the hospitals which, in my opinion, will effect a similar decrease in hysterectomies providing it is made an absolute requirement before every operation of this character. Similar action in the case of curettages is being enforced in several New York hospitals as well as in one in Newark with the result that there has been a decrease in the number of curettages. I trust similar results will follow if this chart is adopted by other hospitals.

The total number of hysterectomies was 2065. Of these, 1710 were in the child-bearing period. (See Figure I.)

ANALYSIS OF HYSTERECTOMIES IN AGE GROUPS

Total number of cases 2065

Represents 6 Hospitals in Newark, N.J. area over a period of 18 months

Age Group	Number of Cases
Under 20	1
20 to 25	19
25 to 30	65
30 to 35	217
35 to 40	422
40 to 45	516
45 to 50	472
50 to 55	353

FIGURE I

The diagnosis of fibroids was made in 1508 cases in this survey—the main symptom being bleeding 1485 times, complicated with pain in 219 cases and large size in 357. Fibroids are the most frequent benign tumors of the female pelvis. Curtis states that one woman in every five after the age of puberty develops such a tumor. It is also asserted that colored women are more prone to this type of growth than white women. This is not borne out by our statistics as there were only 271 colored women in the series.

Novak finds that only 5 per cent of fibroids are of the sub-mucous variety. This type, we all recognize, is the cause of bleeding.

The fact that a woman has a fibroid is, in itself, no indication for surgery. Many are asymptomatic; many gradually atrophy after the menopause. But this seemingly did not occur in the 353 patients who were in the

* Read before the Section on Obstetrics and Gynecology, Annual Meeting of The Medical Society of New Jersey, April 27, 1948. As presented, the paper also included an analysis of pathologic considerations by Dr. S. J. Rose. This will be published in a later issue.

menopausal age. Bleeding seemed to be the most frequent indication for surgery. In this series we had bleeding in 1485 cases; there were also complicating factors. (See Figure II.) As bleeding is a normal function of the uterus, in a great many cases no mention was made as to the duration or amount previous to the present incapacity. Furthermore I was able to find but two cases in which a transfusion was performed. The hemotologic reports showed the majority of counts to be within normal limits.

ANALYSIS OF SYMPTOMS

Total number of cases 2065

Chief Symptom	No. of Cases
FIBROIDS	1508
BLEEDING	1485
PAIN	219
SIZE	357
OTHER EXTRAUTERINE CAUSES, e.g. ovarian tumors, ectopic pregnancies, adhesions etc.	137

FIGURE II

Pain is a relative condition and is more or less dependent upon the sensory threshold of the individual. While fibroids themselves do not cause pain, the fixation of the tumor mass to other viscera may be the cause, twisting of a pedicle, sloughing, impaction or pressure on bladder, in the latter instance even causing obstruction of the ureter. Taking all this into consideration, all of these cases were accompanied by bleeding. Backache and discomfort due to the size were the most frequent complaints.

I was able to see the measurements of 955 uteri that had been removed and found that 366 were about the size of a one month's pregnancy or 8.75 x 6.25 x 6.25. Six were cases of carcinoma of the uterus, 2 of the cervix, 2 of the ovaries, 5 adenomas, 16 polyps, 2 retained secundines and 209 contained fibroids. The remaining 124 were signed out as fibroids, but the pathologic report was "hyperplasia of the endometrium".

Another condition, somewhat similar in symptomatology, but rarely diagnosed before operation is endometriosis interna or as it is designated by the pathologist, adenomyosis. Up to 1884, there had been but 100 cases reported. In 1896 Von Recklenhausen firmly established its pathologic identity. In 1908, he reported 98 cases. There are four types: the diffuse, localized nonencapsulated, submucous and the circumscribed. The theory of Cullen that they are of mullerian tissue origin is now accepted. These tumors are most frequently encountered during the third and fourth decades—although one has been reported in a girl aged 22. Symptoms are not characteristic. On examination, the uterus is moderately enlarged and symmetrical. Suspicion should be aroused if a patient in the fourth or fifth decade should complain of severe pain with an increased flow with a symmetrically enlarged uterus. In such a case, think of endometriosis before you think of a fibroid. One third of all cases occur in sterile women.

It is rather remarkable in a series of this size, that we had such a small number of malignancies—only 87. Wharton gives the following as to the location and frequency of cancer of the female genitalia: 34.3 per cent in the cervix, 12 per cent in the ovaries and 12 per cent in the corpus. In the Negro race only 10 per cent were cervical and 5 per cent endometrial. He says that 75 per cent of malignancies occur in women over fifty. All the cases here reported (with the exception of 8) were in this age group. As to sarcoma, 4 per cent of all tumors of the uterus between the ages of 40 and 60 are of this type. There is another type of malignancy (not encountered in this series) and that is "stump carcinoma". Ackerman and del Regato estimate that it occurs in 2 per cent although in specialized clinics it runs to between 4 and 5 per cent. In this survey 1739 operations were supravaginal hysterectomies and 326 were vaginal hysterectomies. We should therefore expect about 35 stump carcinomas. In a personal reply

from Doctors Watson, Meggs and Williams, the consensus was that the removing of the cervix was more or less a routine procedure with them in hysterectomies. The frequency of ovarian malignancies, I am unable to cite, except that according to Pfannenstiel, sarcoma of the ovary occurs in 5 per cent of all ovarian tumors and that 50 to 75 per cent are permanently cured. Ewing, combining Martin's and Libbert's statistics, states that 22 per cent of ovarian tumors were malignant. Most of these tumors occur between the fourth and sixth decades. Insidious in their growth with a very poor prognosis, they are frequently bilateral and of cystic type.

CHRONIC METRITIS

From the pathologist's point of view, we are confronted with an ambiguous terminology as "metritis" may mean subinvolution, arteriosclerosis, myometrial hypertrophy, chronic metritis or senile endometrium. Novak states that the cause of metritis is puerpural infection, gonorrhea or tuberculosis. This is borne out by Schwartz who finds that 75 per cent are due to adnexal disease; summarizing further he found the endometrium normal in 40 per cent, chronic endometritis in 40 per cent, hyperplasis of endometrium in 15 per cent and senile endometrium in 5 per cent. Many articles have been devoted to the myometrium in the past few years and many have come to the conclusion that the so-called "essential bleeding" or what was also called "myopathiea hemorrhagica" applies to this type of uterus. Novak feels that *fibrosis uteri* and *hypertrophy* are poorly defined terms, not recognized by many pathologists and gynecologists. Hypertrophy, he says, is a rare condition. In our series of prolapsed uteri, the diagnosis was either senile or atrophic endometrium or fibrosis which is the terminal stage of metritis.

The symptoms of chronic metritis are irregular and painful menstruation, leucorrhea and at times a rather severe hemorrhage. At other times the bleeding is scanty and painful.

CHRONIC ENDOMETRITIS

Cullen states that the most notable fact about chronic endometritis is its infrequency. Infections of the endometrium are found only where there is definite pathology in the adjacent tissues. Novak lists two factors responsible for the endometrium's ability to throw off infections unless of a very virulent type. These are: (a) the monthly desquamation of the endometrium of the uterus and (b) the good drainage afforded by the position of the uterus. The designation *hyperplasia* is gradually superseding this term. Alder and Hitschman demonstrated that so-called "endometritis" was a phase in the normal menstrual cycle. Curtis in a joint bacteriologic and histologic study of ground-up endometrium, rarely found evidence of inflammation. Bleeding was the indication for hysterectomy in all of the cases. Terms of excessive bleeding—metrorrhagia, menorrhagia and irregular bleeding—were the most frequent, no mention being made as to previous menstrual history, as to duration, amount or frequency. No transfusions seemed necessary and the blood examinations in most cases were within normal limits despite a history which would lead one to believe to the contrary.

Functional bleeding is a disturbance of the endocrine activities of the ovary or is secondary to a diseased or disturbed function of the pituitary or thyroid or to one or more of the other endocrine glands. While it has been accepted that hyperplasia of the endometrium is due to a stimulation of the estrogenic hormones (not necessarily by hyperestrogenism but by prolonged constant stimulation) in several cases observed personally, the absence of corpus luteum with the occurrence of a follicular cyst would seem to bear this theory out as the removal of the cyst was followed by regular menstruation.

ANALYSIS AND COMMENT

Of 2065 clinical and pathologic diagnosis, a little over 70 per cent (1058) of the cases consisted of myomata. Of these, bleeding was the chief symptom, occurring 1485 times, or 93 per cent. As the exact number of submucous myomata are not available, it is impossible to draw definite conclusions as to how many were actually performed for the control of uterine bleeding. As this type of fib-

CRITICAL ANALYSIS OF DIAGNOSES FOR WHICH HYSTERECTOMY WAS PERFORMED

Survey covering 6 Hospitals in Newark over a period of 18 months.

DIAGNOSIS	NO. OF CASES
MYOMATA, including 17 fibro-polyps	1508
CHRONIC ENDOMETRITIS, with cervicitis	172
CHRONIC METRITIS, (124 prolapsed uteri)	285
ENDOMETRIOSIS UTERI (adenomyosis)	10
CARCINOMA UTERI (fundus)	39
CARCINOMA OF CERVIX	18
SARCOMA OF UTERUS	3
CARCINOMA OF OVARY, (SARCOMA OF OVARY 1)	8
DERMOID CYST OF OVARY	2
PREGNANT UTERUS	4
ECTOPIC PREGNANCY	2
BICORNUATE UTERUS	2
RETAINED SECUNDINES	7
AMENORRHEA	1
NERVOUSNESS	1
ADHESIONS	2
Total	2065

FIGURE III

roid is the one that causes bleeding, these figures are out of all proportion to that of Novak who finds that only 5 per cent are of this variety. No doubt many of the uteri contained intramural or serous fibroids that do not bleed. This would leave the remaining 30 per cent as due to diversified lesions, the diagnosis of which might have been difficult before operation. We were unable to justify the removal of the uterus for such conditions as fibro-polyps, chronic endometritis, dermoid cyst of ovary, ectopic pregnancy, pregnant uterus, bi-cornuate uterus, retained secundines, amenorrhea, nervousness and post-operative adhesions. Chronic endometritis is a misnomer. In 124 cases discharged with a diagnosis of "fibroids", the pathologic diagnosis was "endometritis". These operations could have been obviated had the surgeon secured the facilities of the laboratory. The bleeding might then have been found functional rather than organic. The same condition prevailed among the 336 uteri removed because of size. They were practically within normal limits. It is hard to believe that they caused any great amount of discomfort. Unfortunately, there is a feeling among general practitioners and general surgeons that the simplest way of curing bleeding of uncertain etiology is to remove the uterus. It is my opinion and that of leading gynecologists that unnecessary hysterectomies could be minimized by a more careful consideration of the symptoms and a more earnest attempt at arriving at a correct diagnosis, pre-operatively. The value of a good history is exemplified in chronic metritis. According to Schwartz, 75 per cent of these are due to adnexal diseases (tuberculosis, gonorrhea or puerpural infections). In none of these cases was there any mention in the history or operative charts of any of these possibilities. Only two of the six hospitals have mentioned this pathologic entity. I will not attempt to evaluate the number of the justifiable and unjustifiable operations.

CONCLUSIONS

(1) The errors that have been committed have been those of omission.

(2) Better gynecologic histories are essential.

(3) More diagnostic curettages and vaginal smears are indicated.

(4) More consultations and better supervision should be required.

(5) More and better pre-operative clinical diagnoses are called for.

510 West Market Street

ALTITUDE OF 8000 FEET DOES NOT INJURE HEART

Contrary to widespread belief, living at an altitude as high as 8000 feet is not injurious to the heart, says G. E. Gomez, M.D., of Bogota, Colombia.

Writing in the August 7 Journal of the American Medical Association, Dr. Gomez bases his conclusion on a study of 480 residents of Bogota, which is 8,016 feet above sea level. In none of these residents did he find enlargement of the heart out of proportion to the general build or abnormal variations in blood pressure, pulse, respiration, or number of red blood cells.

Prolonged strenuous exercise can cause enlargement of the heart, he says, but no more so at 8000 feet than at sea level.

MANAGEMENT OF SURGICAL EMERGENCIES IN THE NEWBORN *

B. M. Hogg, M.D., New York, N. Y.

Certain defects of the newborn constitute surgical emergencies and it is important to understand the factors which have made possible recent reductions in mortality.

Of first importance in improving surgical results is early recognition of the problem. This implies, among all concerned, a widespread acquaintance with the possible malformations and recognition of the clinical and laboratory findings produced.

Diagnostic measures are, in general, simple. Thorough physical examination suffices in some instances; in others, the addition of an upright flat plate is all that is necessary. The use of contrast media (with the exception of minimal amounts of lipiodol) is unwise and usually unnecessary.

The newborn seems to be provided with a resistance to trauma (perhaps in preparation for passage through the birth canal) which persists during the immediate neonatal period. This unknown attribute makes prompt attention vital. Consideration should also be given to the dangers of infection and malnutrition which rapidly supervene in these infants. The need for prompt attention does not imply, however, that these children cannot safely be moved even long distances if proper attention is given to supportive measures.

Second only to prompt diagnosis and adequate surgery is preoperative, operative, and postoperative supportive measures which include external heat, oxygen, parenteral fluids, blood, continuous suction drainage, pharyngeal and tracheal suction, and chemotherapy.

Hydration and chemotherapy should begin at once. Approximate fluid requirements are about one hundred cubic centimeters of fluid per kilogram per day, with salt limited to about 250 milligrams per kilogram or 125 cubic centimeters of normal saline. The additional fluid is given as 5 per cent dextrose and water. Protein is urgently needed by these patients and they should receive 10 to 15 cubic centimeters per kilogram of blood, plasma or both at least every other day. These are basic requirements. Unusual losses should be recorded and compensated for as indicated. It is perhaps wise to keep these patients a little on the "dry side", frequency of urination is a pretty good index of hydration. Sodium sulfadiazine may be given in 5 per cent solution as clysis 0.1 Grams per kilogram per day and penicillin 30,000 units every three hours.

Satisfactory continuous infusion can be set up using the plastic tubing for replacement transfusions inserted into an ankle vein. This arrangement will often run for several days at four drops a minute and obviates the necessity for disturbing very ill patients.

Anesthesia should be the responsibility of one accustomed to such cases. Premedication is usually dispensed with and open drop ether is the agent most generally useful. Open chest cases require a tight fitting mask using either ether or cyclopropane. Intratracheal tubes carry considerable threat of laryngeal edema and are usually not necessary. Local anesthesia can be used successfully if necessary.

Technically, surgical procedures involved in these cases do not differ greatly from those encountered in adult surgery. However, experience in operating in confined areas, the use of finest suture and ligature material, and meticulous hemostasis are of great importance.

Hospital equipment required for the care of these cases is usually found on any pediatric service.

The malformations which lead to surgical emergencies center about the gastro-intestinal tract. First group to be considered are the atresias of the esophagus with and without tracheal fistula. In most of these cases, the esophagus ends in a blind pouch at the second or third vertebra and the lower end enters the trachea above the carina.

Clinically these babies show excess salivation and periods of cyanosis usually initiated by attempts at feeding. Diagnosis can be con-

* Read before the Section on Pediatrics, Annual Meeting of The Medical Society of New Jersey, April 27, 1948.

firmed by passing a small catheter into the esophagus and meeting obstruction at about 15 centimeters. X-ray of chest and abdomen gives the level of the pouch and if there is air in the stomach a tracheal fistula exists. A small amount of lipiodol may be instilled through the catheter to rule out stenosis of esophagus or fistula into upper pouch.

Direct anastomosis is the procedure of choice and can be done with great success in most cases. For instance, of the last four cases admitted to Babies Hospital in New York City, all are now doing well. One did develop symptoms of hypertrophic pyloric stenosis two weeks after the esophageal repair and gastrostomy. This was successfully treated surgically.

Diaphragmatic hernia which may give cyanosis or obstructive symptoms early may be suspected on physical examination and confirmed by simple x-ray of chest. These may constitute emergencies and can be successfully repaired through either thoracic, abdominal, or a combined incision.

Malformations of the gastro-intestinal tract below the diaphragm include stenosis atresia, congenital bands, malrotation, and volvulus which present the picture of intestinal obstruction of greater or lesser degree with vomiting, distention and visible peristalsis commensurate with the degree and level of obstruction. An upright flat plate of the abdomen will usually give confirmation of the diagnosis.

Stenosis occurs more frequently in the duodenum and atresia in the ileum. Multiple lesions should be looked for in the stenoses and atresias and constriction of the duodenum by a cecal band in cases of volvulus.

Operative mortality is highest in the low atresias and lower in obstruction due to bands and volvulus. Chemotherapy and better supportive measures have improved the mortality, but it is still discouragingly high.

Simple stenoses of anus and rectum are treated by dilatation and simple imperforate anus by incision and dilatation. Atresias of rectum below three centimeters can be pulled down from a perineal approach with satisfactory result. In atresias higher than this, (if associated with vesical fistulas) the patient should have colostomy and further surgery when older.

Omphalocele is herniation of abdominal contents into the cord. This is easily treated in simple cases. However, when the disproportion between abdominal cavity and extruded contents is great, the problem is a serious one. The objective in such cases is to cover the viscera. If this can be done using undermined skin or skin flaps, the rest of the procedure may be delayed until the abdominal contents and cavity adjust themselves and the hernia treated subsequently.

The experience at New York Babies Hospital in regard to meconium ileus is unique and with the permission of Dr. Hiatt and Dr. Wilson, I would like to mention our experience with eight cases which were diagnosed and operated on during the past two years. Five survived operation. One died subsequently of pulmonary disease, two are living with some evidence of pulmonary disease, and two are well. All five have cystic fibrosis of the pancreas. We also had one case of meconium peritonitis with a low perforation which was closed. The child is now well without evidence of other disease.

Early recognition and close cooperation between the pediatrician, obstetrician, and surgeon is essential if surgical emergencies of the newborn are to be treated with increasing success.

180 Fort Washington Avenue

ENTERIC EMETINE

In treating intestinal amebiasis, emetine hydrochloride can be effectively administered in enteric-sealed tablets which should not dissolve until reaching the terminal ileum or colon four hours after ingestion. Toxic or emetic effects were not observed by Shrapnel, and associates, in successfully treating 15 of 20 patients at the Gorgas Hospital. Usual procedure was to give 2 gr. daily for six days in the form of two tablets of 1/3 gr. each, three times a day. —*Am. J. Trop. Med. 26:293.*

DIETARY MANAGEMENT OF DIABETES MELLITUS *

SELMA WEISS, M.D., Newark, N. J.

The systematic treatment of diabetes mellitus dates back to 1796 when John Rollo,[1] a surgeon in the English Army, treated a soldier suffering from diabetes mellitus, with a diet consisting almost exclusively of animal food. Not much change in dietary management took place until the middle of the nineteenth century. Even then, since the disease was little understood, the treatment was carried out on a trial and error basis. It was not until the end of that century, that the beneficial effects of caloric restrictions and fasting were really recognized, although Bouchardat, (one of the most brilliant clinicians in the history of diabetes), introduced fast days for the treatment of diabetes. He noticed the disappearance of glycosuria in diabetes during the siege of Paris. He was the first to recommend the boiling of green vegetables and throwing away the water to diminish their starch content. He introduced gluten bread and was the first to insist on the need of individualizing the treatment for each patient.

During this period, bread substitutes became popular. Gluten bread was followed by Prout's bran bread and Pavey's almond bread. Soya bean bread [1] and other preparations were used by the French as early as 1888.

Cantani, of Italy, gave us, in 1890, the most powerful impetus to rigid dietetic treatment. He asserted that the metabolism is disturbed by an excess of any constituent in the diet and if the excess is prolonged, the disorder becomes permanent. The essential contribution made by Cantani [1] was the strictness of the diet and insistence on sugar free urines. He would keep patients under lock and key in order to make sure that they ate nothing but the prescribed diet.

About this time, special food "cures" came into use. These consisted of individual food stuffs: such as the "potato cure" of Von During (1852), the "rice cure" of Mosse (1829), the "milk cure" of Donkin (1869). Best known of these was the "oatmeal cure" of von Noorden (1902). Other similar "cures" followed and were used as late as 1920 when Falta advocated the "mixed cereal cure".

While all these diets and food "cures" produced some favorable results, they were impractical and unsatisfactory. The beneficial effects of these diets were attributed to the fact that the carbohydrates were given in a single form or to the fact that the particular carbohydrate in a special cereal had certain curative properties. It was also thought that the bland nature of the diet or its low protein content was of value. We have since learned that whatever beneficial effects these "cures" had, were simply due to the low caloric intake.

The next marked advance in the dietary treatment of diabetes mellitus was introduced with the Naunyn era 1894 to 1914. Although the principles of dietetic management had already been recognized, their application was inefficient. Naunyn, a follower of the Cantani system individualized the dietary regimen. He prescribed a diet for each patient which took into consideration both the carbohydrate tolerance and the patient's caloric requirements. When carbohydrate restriction was not sufficient to control the glycosuria, he restricted the protein as well, giving 40 to 50 Grams of protein daily. Like most of his predecessors, Naunyn, considered fat the chief food for a diabetic. He increased the carbohydrate only when acidosis threatened. His reason for limiting fat were "indigestion" and coma.

Not much progress was made in this field at the beginning of the present century. The regimen still consisted of a low caloric diet, high in fat, low in carbohydrate and low in protein. Guelpa, (1913), argued that all diseases were due to auto-intoxication. He therefore used long periods of fasting, from two to three days at a time, with purgation. He also emphasized the value of weight loss in the treatment of this disease.

In 1914, Allen [2] demonstrated. from studies on partly depancreatized dogs and from careful clinical observations, that glycosuria could be checked by fasting, even in severe cases, and that life could be maintained by an extremely

* Presented to the Annual Meeting, The Medical Society of New Jersey, April 29, 1948.

1. Allen, F. M., Stillman, Edgar and Fitz, Reginald: *Total Dietary Regulation in Treatment of Diabetes Mellitus.* The Rockefeller Institute for Medical Research, 11:1, (1919).

2. Allen, F. M.: Journal of the American Medical Association, 11:939, (September 12, 1914).

small amount of food. His method involved an initial period of fasting, up to three or more days, until the urine was sugar free. He started with 10 to 40 Grams of carbohydrate which was divided in four to ten equal portions. If the urine remained sugar free, the carbohydrate was doubled the next day. If the urine still was sugar free carbohydrate was increased to about 100 Grams daily. He tried to keep the metabolism at the lowest safe level until the patient could take 100 to 150 Grams of carbohydrate daily. Fast days were interposed often enough to prevent any trace of glycosuria. Protein was added cautiously until patient received 0.66 Grams of protein per kilogram of body weight. Fat was used to make up the balance of the caloric prescription. However, the total number of calories was kept low, seldom exceeding 1200 calories.

Emphasis was placed by Allen on complete control of glycosuria and on keeping the body weight well below normal limits. He wrote that he began his experiments:

"With a view to the possibility that diabetes is a disorder of the total metabolism, and not of carbohydrate utilization alone, that the entire diet and maintenance of the entire body mass constitutes a load upon the internal function of the pancreas, and that accordingly in the treatment of diabetes, increase of diet and of body weight increases the strain upon this function."

The mild diabetic fared nicely on this regimen. Not so, the severe diabetic. While this often kept the patient sugar free, prolonged his life and reduced the incidence of coma, it was a miserable existence. He was constantly hungry, and so emaciated and weak that he was unable to carry on.

Attempts to increase the diet to overcome this emaciation and weakness, resulted in glycosuria and often ketonuria. Woodyatt[3] in 1921 overcame some of this difficulty by introducing the balanced diet and pointing out that more food could be utilized as long as a fat to carbohylrate ratio of 1.5 to 1 was maintained.

Newburgh and Marsh[4] experimented with higher fat diets. They felt that the trouble with the former diets was, that they consisted largely of protein and too little fat because of fear of acidosis. The diets that contained higher protein, low fat and low carbohydrate given in sufficient quantities to maintain metabolic needs, resulted in glycosuria in severe diabetics. To prevent glycosuria, the diet was so low that inanition resulted. Since carbohydrate and protein could not be given in sufficient amounts to prevent glycosuria, they ignored the danger of ketosis due to fat and experimented with high fat diets to which was added sufficient protein to keep patient in nitrogen equilibrium. The initial diet yielded 900 to 1000 calories and consisted of fat 90 Grams, protein 10 Grams, and carbohydrate 14 Grams. Patients were kept on this diet from one to two weeks. The diet was gradually increased so that most patients received an 1800 calorie diet consisting of fat 170 Grams, protein 30 to 40 Grams and carbohydrate 25 to 30 Grams.

Following the introduction of insulin in 1922, there was no immediate radical change in the dietary management of diabetes. Most clinicians continued to use the high fat, low protein and low carbohydrate diets.

Among the first clinicians to attempt more liberal carbohydrate diets were Sansum and Geyelin in this country, Adlersberg and Porges in Austria and Rabinowitch in Canada.

Sansum[5] tried the high carbohydrate diet in 1926 on a patient who was well controlled with high fat diet but who did not feel well in spite of it. Upon increasing the carbohydrate in the diet, besides being well controlled, the patient experienced a sense of well being. Sansum used diets employing 2 Grams of carbohydrate to one Gram of fat. Of course, insulin dosage was increased.

Geyelin[6] in 1925 resorted to even higher amounts of carbohydrate. He asserted that the effectiveness of insulin increased as the fat in the diet was decreased, and that the effectiveness of insulin was not fully attained until a certain lower level of fat was achieved. This maximum effect of insulin was reached when

3. Woodyatt, R. L.: Archives of Internal Medicine, 28:125, (August 1921).
4. Newburgh, D., and Marsh, J.: Archives of Internal Medicine, 26:647, (December 1920).
5. Sansum, W. D., Blatherwick, N. R., and Bowden, R.: Journal of the American Medical Association, 86:178, (January 16, 1926).
6. Geyelin, H. R.: Journal of the American Medical Association, 104:1203, (April 6, 1935).

3 to 4 Grams of carbohydrate to one Gram of fat were given. The increase of insulin after the change from low to high carbohydrate was only temporary. Like his predecessors, he advised against over-nutrition. After ten years of this regimen he observed: (1) that there was no loss of carbohydrate tolerance, (2) that there were fewer insulin reactions, (3) that the blood cholesterol was normal, (4) that complications were less frequent and, (5) that the incidence of cardio-renal disease was decreased.

The tendency toward the high carbohydrate diets approximating the normal continued. In 1935, Rabinowitch,[7] an advocate of the high carbohydrate, but low calorie diet said that:

"The high carbohydrate diet is here to stay and that the favorable results are reflected in the general condition of the patient and are particularly well supported by the laboratory findings and reduction of insulin dosage."

Watson[8] of Canada in 1936 undertook an intensive investigation of diabetics of different ages and various grades of severity to compare the values of types of diets advocated by different clinicians. The diabetes was first stabilized on a standard diet which consisted of fat 60 per cent, carbohydrate 25 per cent, protein 15 per cent. Then the following test diets were used: Newburgh's high fat diet, Rabinowitch's high carbohydrate diet and other combinations of fat and carbohydrate. His conclusions were as follows:

1. There was no conclusive evidence that the blood cholesterol varied appreciably with fat content of the diet. High levels were found frequently at the beginning of the investigation, which fell to low levels irrespective of treatment. Only when the fat content of the diet was increased greatly, was there a tendency towards an increase in cholesterol.

2. *High fat and low carbohydrate*—The insulin requirement was reduced or eliminated altogether although the requirement for insulin was greater in proportion to the total glucose content of the diet than with the higher carbohydrate and lower fat. Low carbohydrate, high fat caused a decline in carbohydrate tolerance and favored ketonuria.

3. Many patients tolerated the high carbohydrate diet provided the fat was low. Raising the carbohydrate intake did not require a permanent increase of insulin, because a higher carbohydrate diet caused an improvement in glucose tolerance.

4. Most satisfactory tolerance for carbohydrate was achieved when the fat content was approximately 100 Grams per day. Over 125 Grams of fat diminished the carbohydrate tolerance.

5. Diets low in fat were not appreciated as much as diets which contained slightly larger amounts.

6. The most acceptable diet from the patient's point of view, was the liberal carbohydrate diet with fat ration of 100 Grams. This approached most nearly the normal diet.

7. Higher carbohydrate diets promoted a state of physical well being and was therefore more conducive to cooperation on the part of the patient.

My own experience tends to corroborate Watson's conclusions.

Early in the last decade, a number of European clinicians began to urge the "normal" or "free" diet, especially for children. Lichtenstein[9] of Sweden feared that when children were restricted and treated as exceptions, their psychic development was impaired. He said that when children are put on a free diet, they first go for carbohydrates, then simmer down and choose between 150 and 250 Grams of carbohydrate daily. Advocates of this high carbohydrate regimen report that diabetics enjoy a higher sense of well being, have less desire to break the diet and are less susceptible to ketosis and infections. The increase in insulin is not as great as expected, the blood sugar is more uniform and the danger of reaction is not so great.

These so called "free diets" are not truly free in the sense that the patient can eat anything at any time. The "free diet" simply permits a liberal carbohydrate allowance—but not an unlimited amount as the word "free" would imply. Whatever the amount of carbohydrate is selected, that amount must not vary from day to day. Concentrated carbohydrates are not advocated.

Tolstoi,[10] introduced revolutionary concepts of dietary control. He is an advocate of the "free diet" and uses from 200 to 300 Grams of carbohydrates daily.

The dietary scheme followed by the group at the Newark City Hospital since the discovery of insulin has been one which leans

7. Rabinowitch, I. M.: Canadian Medical Association Journal, 26:141, (February 1932).
8. Watson, E. M. and Wharton, M. A.: Quarterly Journal of Medicine, 4:277, (July 1935).
9. Lichtenstein, A.: Journal of Pediatrics, 12:183, (February 1938).
10. Tolstoi, E.: Journal of Digestive Diseases, 10:247, (July 1943).

towards a higher carbohydrate intake, a moderately low fat and sufficient protein to meet the individual needs. In the early days of insulin, carbohydrate in the diet averaged 125 to 150 Grams per day. Protein was calculated at one Gram per kilogram of body weight unless there was kidney involvement. A higher amount of protein was generally allowed children and adolescents. Fats were kept low at the onset of the treatment. When the diabetes was controlled, the fats were increased until the patient attained the desired weight, normal or slightly below normal. With more experience in the use of insulin and following the general trend, the carbohydrate was increased from 150 to 200 Grams daily.

The protein content of the diet varies with the condition of the patient. In an uncomplicated diabetic, we give from 1 to 1½ Grams of protein per kilogram of body weight. In diabetes associated with large loss of albumin in the urine, (or in certain liver complications) we give even more protein. We do not estimate the caloric needs of the patient, but are guided by the weight of the patient. Since the goal is to bring the patient's weight to slightly below normal, the obese patient is denied fat, while the lean patient is given enough to cause gradual gain in weight. When all fats are denied, patients are given supplements of vitamin A and D. Duncan,[11] who does advise a caloric prescription, suggests 18 calories per kilogram of the standard body weight in an obese diabetic, 25 calories per kilogram of the standard body weight in a diabetic of normal weight and 35 calories per kilogram of the standard weight, in the underweight.

To insure a well balanced diet rich in vitamins and minerals and a proper mixture of fast and slow carbohydrates with each meal, we use the skeleton diet. This contains most of the carbohydrate foods that the patient will eventually take. The skeleton diet consists of one quart of milk, one helping of cereal, (30 Grams of uncooked cereal), six slices of bread (180 Grams) three helpings of 10 per cent fruit usually given as orange juice (four ounces with each meal or its equivalent). This diet contains carbohydrates 200 Grams, fat 42 Grams, and protein 55 Grams. If there are no gastrointestinal complications we add one helping (four ounces) of meat, one helping of cheese, an egg, and a liberal amount of 5 per cent vegetables. Fats are not added to the diet until the patient is controlled. Ultimately, this diet may contain 200 Grams of carbohydrates, 90 Grams or more of protein, and from 80 to 100 Grams of fat.

In the early days all the food was weighed. For convenience and psychologic effect we have abandoned the "weighed" diet and now use the "measured diet" in household terms.

Distribution of the carbohydrates during the day depends on the type of insulin and the number of injections given. When regular insulin is used before breakfast and the evening meal, the carbohydrates are divided into three equal parts. At times, a small amount of carbohydrate is given as a mid-morning snack. This is done to avoid a four-plus sugar in the urine after breakfast and a reaction before luncheon. When protamine zinc insulin is used, the carbohydrate quota for the day is divided into four portions with breakfast containing the least amount of carbohydrate, larger amounts for luncheon and dinner and a bedtime snack of 20 to 30 Grams. A small amount of protein may be given with this bedtime snack. This snack protects against reaction in the early hours of the morning. When insulin mixtures or globin insulin are given, the carbohydrate quota for the day is divided into four or five portions. The smallest amount of carbohydrate is given in the morning, a larger amount at noon, a snack of about 20 Grams of carbohydrate in the late afternoon and the remainder of the carbohydrate is divided between dinner and a small snack at bedtime.

Only the carbohydrate foods, or as we refer to them the "essentials" are measured, even though the measuring is done with household utensils. The patient should be taught how to substitute various items in the diet in order to avoid monotony and the temptation to break the diet. We always keep in mind the patient's former food habits and tastes. We

11. Duncan, W.: *Diseases of Metabolism*, 2nd edition, Saunders, Philadelphia, page 751, (1947).

do not encourage the use of special food such as: diabetic cookies, special bread and jelly. Water-packed fruit and flavored gelatin preparations are permitted. Coffee, tea, broth and tomato juice are permitted with or between meals. Brandy, whiskey and dry wines may be used in moderation.

The routine followed at the Newark City Hospital has no particular advantage over other well recognized methods, except for its greater simplicity for "the best diet is of no value if the patient cannot keep it". Questions as to which is the best diet for adequate control, for keeping the patient well and happy and for minimizing or delaying vascular complications, (assuming that the vascular complications are related to the diet), are still unanswered. There is only one factor upon which all are agreed, and that is, the limitation of the caloric intake.

190 Clinton Avenue

CALCULATING THE HOUR OF BIRTH

Smyers has worked out a graphic method for predicting the hour of birth in normal labor. The interval between pains is calculated in minutes, and this is plotted on ordinary graph paper against the clock time of the pain. If the average of several consecutive intervals is used as the plotted "interval" point, a straight line may usually be drawn between successive interval points. This straight line is then projected until it intersects the "zero" interval line (interval zero) and this indicates the expected clock time of the birth.

Using this method in twenty normal births, Smyers found an average difference of only fifteen minutes between the actual birth time and the time as computed by the graph. In half the cases, in fact, the error was less than ten minutes. In abnormal births, the graph may suggest optimum time for interference. Failure of birth to occur within a half hour or so after the computed time, may indicate the need for interference.

—Hexagon of the Alpha Chi Sigma 32:267

IS SYPHILIS DISAPPEARING?

The incidence of active or transmissible syphilis *declined* during the war year (the apparent incidence based on serologic survey went up). Syphilis is actually a disappearing disease. Credit for this disappearance does not accrue, however, to the medical profession. Actually the *Treponema* has been undergoing an evolutionary change for years in spite of us.

We have no evidence for, and some against, the common assertion that syphilis is now a disease of the colored races. It appears now that some portion of the high serologic incidence in both the American and African Negro is merely a reflection of racial hyperglobulinemia.

No adjudication can actually be made between "false" and "true" syphilis seropositivity on the basis of any verification procedure, on the type of test, the titer reached, or the duration of the positive reaction. There is no specific test for syphilis except clinical acumen. To incriminate a person for syphilis on the basis of any blood test is irrational.

At least 35% of the subjects treated for syphilis in the armed forces never had the disease in the first place.

R. D. BARNARD, M.D.,
Modern Medicine, 1947

DIABETES AND PREGNANCY

Diabetic women can give birth to living babies in 90 out of 100 cases when suitable sex hormone treatment is given during pregnancy, according to Priscilla White, M.D.

Disturbances of the hormones are the most important factor threatening harm to the unborn babies of diabetic mothers. This condition was found in 75% of cases studied by Dr. White. When present, half the unborn babies died before birth, but when the condition was corrected, 90% survived.

The tendency to diabetes is inherited, being transmitted through Mendelian recessive genes. They advise against intermarriage of two diabetics or of a diabetic with a person known to be a hereditary carrier.

STATE ACTIVITIES

THE VA FEE SCHEDULE: A COMMENT AND AN EXPLANATION

Following is the text of a letter prepared by the Chief Medical Director of the Veterans Administration for distribution to all state medical journals:

It has come to my attention that misunderstanding has developed throughout the medical profession concerning the establishment of fees for medical services to be paid private physicians participating in the so-called "Home Town Medical Care Program for Veterans". It has been contended that the Veterans Administration has arbitrarily established a fee schedule which represents the maximum amount which may be paid for any given service and which is, in effect, a national schedule. It has also been contended that state medical societies and other interested groups were not consulted when this schedule was adopted.

To clear up any misunderstanding regarding this matter, it is desired to emphasize that my predecessor, Dr. Paul R. Hawley, had no intention at any time of establishing a national schedule of fees, nor do I contemplate doing so. However, the fee schedules originally submitted by the state medical societies, when the "Home Town Medical Care Program" was inaugurated, varied so widely in format, terminology, and fees for similar or identical services, that it was deemed advisable to establish a uniform fee schedule format and to set up tentative fees which could be used as a guide by the state medical societies when submitting proposals for furnishing of medical care to veterans.

This uniform fee schedule format was formulated by the Professional Group of National Consultants to the Chief Medical Director. This Group, representing the various specialties in medicine and surgery, is composed of eminent physicians from all parts of the country. Tentative fees were set up in the format after careful analysis of pre-paid medical care plans, workmen's compensation and insurance fee schedules, and also the fee schedules in effect in the various states having agreements with the Veterans Administration. As was to be expected, considerable variation was found.

The Professional Group of National Consultants made every effort to arrive at fees within reasonable limits,—fees which would, as nearly as possible, allow a uniform provisional fee schedule for use as a guide in facilitating and expediting the preparation of agreements between state medical societies and the Veterans Administration.

Further attempt was made to provide for elasticity in the charges for certain operations or other services which seemed to evoke more than average contention by listing the minimum and maximum amounts considered equitable. These items bear the notation "AA", which indicates that the fee for the given service is to be determined by arbitration and agreement between the Veterans Administration and the medical society concerned.

The Veterans Administration Fee Schedule format is in no sense to be construed as an arbitrary or national fee schedule. Furthermore, it is subject to periodic review and such modification as conditions may indicate.

Very truly yours,

PAUL B. MAGNUSON.

SUPPLEMENTARY LIST No. 6
TO THE
1948 OFFICIAL LIST OF MEMBERS

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Banta, Edward E., 64 Peters pl., Red Bank (13)
Barfeld, Benjamin B., 509 Landis av., Vineland (6)
Calabrese, D. John, 114 Rochelle av., Rochelle P. (2)
Ciliberti, Frank J., Fifth and Pine sts., Camden (4)
Collis, Abraham S., 156 Atlantic av., Lg. Branch (13)
Drucker, Victor, 154 Plauderville av., Garfield (2)
Duffy, Joseph F., 387 Kinderkamack rd., Westw'd(2)
Galotta, Margaret L., Holy Name Hosp., Teaneck(2)
Guidice, Vincent W., Harrison av., Waldwick (2)
Hubbard, Samuel T., 241 Main st., Hackensack (2)
Leonard, Frederick S., 32 E. Clinton av., Tenafly (2)
Luria, Sanford A., 249 Queen Anne rd., Bogota (2)
Marchigiano, Michael A., 88 Westfield av., Clarktownship (Rahway) (20)
O'Brian, E. Raymond, 101 West 7th st., Plainfield(20)
Power, William R., Bound Brook (18)
Schliffman, Samuel, 107 Spruce st., Newark (7)
Schneider, Leo, 39 Hillside av., Newark (7)
Shepard, Adele C., 818 Summer st., Elizabeth (20)
Vaughn, James Maurice, 825 Kaighn av., Camden(4)
Villardo, Ross, 109 Marcellus pl., Garfield (2)

THE SOCIETY FOR THE RELIEF OF THE WIDOWS AND ORPHANS OF MEDICAL MEN OF NEW JERSEY

A Helping Hand Organization for New Jersey Physicians, Which Procures Its Funds by Assessments of Its Members, Endowments and Donations

Objects: To provide immediate financial aid to those who have been dependent on a deceased member: to assist a member disabled through sickness or misfortune by lending him money without collateral or interest: to assist a widow or children of a deceased member, who has exhausted his resources because of illness or investment losses previous to his death.

The Society does not pay a definite sum at the death of a member. The amount varies depending on the number of members on the rolls at the time the assessment is called. Since 1945, with our present membership, the benefit amounts to about $445. Our By-Laws provide that the widow receive 75% of every dollar paid in by the members. The remaining 25% is used to defray necessary Society expenses. The unexpended balance of this 25% is placed in our Permanent Fund to provide income which may be used to help needy widows and children of deceased members.

The Permanent Fund has grown rapidly, now amounting to nearly $80,000, and provides an annual income of $2000. No portion of the Permanent Fund can be spent for any purpose whatsoever, but the income from it may be used to dispense aid to needy widows and orphans of deceased members.

In addition to the payment of the regular death benefit, the Society can assist widows whose income ceased at the death of their husbands, and who have little or no earning power. The Society has often donated the extra contributions to worthy widows for more than 20 years after the death of a member.

This Society is a cash organization: When the members pay the treasurer, the treasurer pays the benefit. As soon as he receives the vouchers from the family, a substantial payment is immediately sent as directed by will, or in the absence of a specific clause in the will, to the widow. If there is no widow, to the children. The balance of the benefit is paid when all the members pay the assessment. We are always one assessment ahead, so there is no delay in payment.

ANNUAL COST PER MEMBER

With our present membership we lose by death 13 members each year. A member joining the Society before age 50 pays $1 per death. If he joins between 50 and 55 years he pays $2 per death. Between 55 and 60 years, $3, and between 60 and 65 years, $5. The Society does not accept applicants over 65 years old. The treasurer notifies the membership of each death as it occurs, together with a statement of the member's indebtedness to the Society at that time.

No one is paid commissions of any kind.

REASON FOR JOINING

This Society is a real "helping hand organization". It provides a sum sufficient to carry the deceased member's family over the depression period when ready money is not available, or until the member's estate is nearing settlement. Every physician in good standing in New Jersey is eligible. At small cost he can help provide aid to a professional brother in distress or to his family, and when a member dies, it is comforting to know he has helped provide financial assistance to the bereaved and often very needy family. Many physicians and their families are not in need of this "helping hand". In such instances, professional benevolence can be arranged so that the amount of the benefit may be returned to the Society, added to the Permanent Fund and invested in securities. This added income is distributed by donations to widows and orphans in need of assistance.

HOW TO JOIN

No medical examination is required. The application blank requires only the name of the applicant, age, address, date of graduation and medical school. The applicant must be sponsored by two members. Send the application to the president or the secretary, together with $2. for the initiation fee, and the amount of the first assessment (depending upon your age). Your election will follow in a few days.

After you have been elected, change of residence does not affect membership. Once a member, always a member, if assessments are paid.

Charles G. Crane, M.D., Secretary
78 Farley Avenue, Newark 8, N. J.

BARBITURATE DEATHS

Several comments have been received on the editorial which appeared in our October JOURNAL discussing the barbiturate deaths. Particularly interesting is a letter from the executive officer of the Pharmaceutical Association which agrees with the sentiments expressed in the editorial but deplores the emphasis given in the general press. An abstract of the letter follows:

Dear Doctor Davidson:

I am pleased with the manner in which the editorial focussed attention on the responsibility of physicians in the distribution of barbiturate drugs and am confident that it will be helpful in curbing the misuse. I sometimes wonder whether the general publicity given to barbiturates is in the public interest. Approximately 1,800,000 prescriptions were dispensed to the public (during that six-month period) containing barbiturates. This indicates that about one out of every hundred-thousand barbiturate prescriptions is misused. Does this experience warrant the type of information which leads the public to believe that physicians and pharmacists are careless in the handling of this drug?

JOHN J. DEBUS, Secretary
New Jersey Pharmaceutical Association.

THE NEW JERSEY HEALTH AND SANITARY ASSOCIATION

Just as the The Medical Society of New Jersey pioneered in raising the standards of our profession, so did the New Jersey Health and Sanitary Association pioneer in raising public health standards of New Jersey. We started our pioneering efforts in 1766 and the New Jersey Health and Sanitary Association in 1874. Both organizations are now the recognized spokesmen for their respective fields.

Medicine in New Jersey has reached the stage where those who are concerned with any phase of public health welfare lean upon the Medical Society for assistance in their efforts. As an organization, we have broadened the scope of our activities by becoming directly affiliated with a number of health-minded organizations. In so doing, we meet our responsibility in lending influence as an organization to better public health programs. Individual physicians, too, must be in a position to keep adequately and properly informed of what is going on in the field of public health to meet their individual responsibilities.

One way of meeting this challenging responsibility is to hold individual membership in the New Jersey Health and Sanitary Association, the membership of which is now largely comprised of members of the allied medical professions. The frequent *News Letters* distributed by the Health and Sanitary Association to its members contain more recent and authentic information on local developments and needs of public health than is available anywhere else.

Dues in the N. J. Health and Sanitary Association are only $2 a year. The prestige of membership in this old and honorable organization, plus the enlightening and frequent *News-Letters* are together worth more than that amount. Membership applications should be sent to

N. J. Health and Sanitary Association

P. O. Box 1, Freehold, N. J.

OBITUARIES

DR. STELLA C. FISHER

Dr. Stella C. Fisher, one of Camden's first women physicians, died at the home of her son in Greenville, S. C., on September 28.

Dr. Fisher was born in Camden in 1884 and was a graduate of the Women's Medical College of Pennsylvania. She had practiced in Camden for 30 years, retiring three years ago. She was a member of the Cooper Hospital staff.

DR. CLARENCE M. TRIPPE

Dr. Clarence M. Trippe of Asbury Park and West Palm Beach, Florida, died in West Palm Beach on August 24.

Dr. Trippe was born in Versailles, N. Y., in 1884, and practiced medicine in Asbury Park since 1915. He received his medical degree at North Carolina Medical College in 1911. He was a Fellow of the American College of Physicians.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

PENICILLIN FOR AMBULATORY SYPHILIS

As long as the supply lasts, the Division of Venereal Disease Control will replace procaine penicillin to physicians who have used it in the treatment of early cases of syphilis (of less than one year's duration). To secure replacement of penicillin used, the physician must:

1. Report the case (this should be done as soon as the diagnosis is made).
2. Indicate on the back of the report card that penicillin is to be used.
3. Upon receipt of the report card a form (VD 177a) is sent to the physician to be filled out when treatment is completed.
4. When this form is returned, indicating that treatment has been completed, replacement is made of two vials (10 cubic centimeters each) procaine penicillin.

Through a grant from the U. S. Public Health Service, the Division of Venereal Disease Control has a supply of penicillin in oil and beeswax which is available to physicians for the treatment of all classifications of syphilis. Note on the back of the report card that P.O.B. is requested and two vials (10 cubic centimeters) will be sent immediately. Some physicians object to beeswax preparations. However, until the last year this type of preparation was the only satisfactory one available for ambulatory treatment and was used extensively.

We are reserving the preferred procaine product for the early cases, because this is the more important group to reach for the protection of the public health.

RE-TREATMENT OF SYPHILIS

Further experience with penicillin indicates that physicians probably have expected reversal of the blood test too quickly. In most patients who have had the disease for two months or longer, four to twelve months or longer will be required to attain seronegativity following penicillin therapy.

Monthly quantitative tests measure the response to treatment. As long as the trend in titer is downward, the serologic progress is considered satisfactory. Quantitative blood tests should be requested, of course, only as long as the result is plus four in the undiluted serum.

Serologic relapse is indicated by a sustained rise in titer (in at least twice the highest dilution which has given a plus four result previously) in two or more successive tests. Do not be misled by rises in titer which may be produced by pneumonia, malaria, other febrile diseases and other conditions producing false positive tests such as severe vaccinia and infectious mononucleosis. Minor fluctuations also may be caused by the all too common daily variations in laboratory technic. Re-treat only in cases of significant serologic relapse.

TREATMENT OF NEUROSYPHILIS WITH PENCILLIN ALONE

Dattner* reports the experience in the treatment of neurosyphilis at Bellevue Hospital, using penicillin alone. He sums up as follows: "Of 301 patients with active neurosyphilis treated exclusively with intramuscular injections of penicillin, and followed from six to forty-five months, only 11 per cent had to be retreated and of the original failures over half have responded well to a second treatment with larger total doses of penicillin alone. The results in the remainder are still undetermined."

GRANULOMA INGUINALE

The number of reported cases of granuloma inguinale in New Jersey is small (seven in 1948), but there is evidence that the disease is more prevalent than reports indicate. The literature about this disease is confusing and outmoded. However, new interest has developed because of the favorable response of this disease to streptomycin.

Practitioners who have a patient believed to be suffering from this disorder may obtain diagnostic and therapeutic suggestions by writing to the State Department of Health, Trenton 7, N. J.

* Treatment of Neurosyphilis with Penicillin Alone. American Journal of Syphilis, Gonorrhea, and Venereal Disease, 32:399 (July1948).

COUNTY SOCIETY REPORTS

GLOUCESTER COUNTY

L. K. Collins, M.D., Reporter

Dr. Frederick J. Faux presided at the initial autumn meeting of the *Gloucester County Medical Society* held at the Woodbury Country Club, September 16, at 9 p. m.

Dr. Herman Wright reported that his committee had reached an agreement with the Gloucester County Welfare Board regarding payment for Old Age Assistance clients. His committee was also assigned the task of formulating and consummating a plan with the State Board of Child Welfare allowing them the free choice of physician and increasing the fees to $2 and $3.

Dr. Faux appointed the Executive Committee with the addition of Dr. Wright to meet with a group of citizens who had expressed the desire to erect a hospital in Gloucester County, this committee to serve in an advisory capacity only.

Clarence Livengood, M.D., newly elected professor of dermatology at the Jefferson Medical College of Philadelphia, then discussed "Modern Diagnosis and Treatment of Superficial Infections of the Hands and Feet". This very interesting and educational paper was illustrated with lantern slides. Following a lively discussion period, the members partook of refreshments, and adjourned at a late hour.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society inaugurated its new season auspiciously on October 5, 1948, when the first regular monthly meeting of the season took place at Murdoch Hall, Jersey City Medical Center. Dr. P. A. D'Acierno presided.

Dr. Joseph F. Londrigan, chairman of the New Jersey Physicians Committee, outlined the current operations of the National Physicians Committee and urged that, in addition to financial support, every member of the Society lend his moral support to N. P. C. by registering in writing, his approval of the objectives of this organization.

Following a brief explanation by Dr. Donnelly of the proposed Memorandum of Agreement being negotiated by and between the County Medical Society and the County Welfare Board with reference to Old Age Assistance, the Society went on record as favoring the completion of this Agreement.

The Society was honored by the presence of Dr. Frank H. Lahey, head and founder of the famous Boston clinic, as its guest speaker of the evening. Before presenting his scientific subject, Dr. Lahey made an eloquent personal plea that physicians join forces with the National Physicians Committee at once—before it is too late to save American medicine and American ideals from the dangers that threaten them on all sides. Dr. Lahey described in stirring language some of the implications of federalized medicine.

The scientific subject selected by Dr. Lahey was *Our Experience with Some of the Newer Developments in Thyroid Disease, Including the Anti-Thyroid Agents.*

MIDDLESEX COUNTY

A. J. Pellicane, M.D., Reporter

A special meeting of the *Middlesex County Medical Society* was held on June 9, at the Roosevelt Hospital, Metuchen. The meeting was called to order at 9:10 by Dr. Edward F. Klein, President.

A motion was passed that we rate the dues of newly accepted members at the rate of 1/12 of the annual assessment for each remaining month in the calendar year.

Dr. Carlyle Morris reported on medical practice for holidays and week-ends and submitted the following outline to provide adequate medical care to assure 24 hours' coverage at all times: "Physicians are desirous of giving prompt and efficient medical service under all conditions and circumstances consistent with the high ethical and moral standards of the profession of medicine. Furthermore, the members of the Middlesex County Medical Society consider that any plan and established practice for rendering medical service should be the result of study and practice among physicians in each hospital, city and community locally with the support of the Middlesex County Medical Society.

"It is therefore the sense of this meeting of the Middlesex County Medical Society that the following be initiated:

"1. A list of physicians available for rendering medical services at night, on a holiday and on Sunday be made by physicians in each locality and copies of this list be made available to the Physicians' Exchange, where one exists, the Police Headquarters, the local telephone exchange, and the local hospital where practical.

"2. That physicians establish different afternoon and evening holidays, especially physicians desirous of accepting professional calls at night, on a holiday, and on Sunday.

"3. That all physicians make adequate arrangements with another physician to accept calls in their absence from their office or home, or their inability to accept night calls, calls on holidays and Sunday, and at any other time.

"4. That publicity be given by all available means to the fact that there are physicians on duty at all hours of the day and night in hospitals of the county that render medical service for any emergency where the individual might be transported to the hospital."

Dr. F. M. Clarke reported on the Post Graduate course, sponsored by Rutgers University. The following courses are to be proposed: bio-chemistry,

surgical anatomy, surgical pathology and nutrition and endocrinology.

Dr. F. M. Hoffman continued the reading of the Code of Ethics, which was approved by the members of the society present, with the exception of one section—which is to be considered further at a later date.

Dr. F. S. Taber gave a brief report of the Annual Meeting of The Medical Society of New Jersey.

MONMOUTH COUNTY

Lester A. Barnett, M.D., Reporter

The regular monthly meeting of the *Monmouth County Medical Society* was held on September 22, 1948, at the Monmouth Memorial Hospital, Long Branch, with Dr. Frank J. Altschul, president, presiding.

Dr. James D. Schofield, professor of proctology, Hahnemann Medical School, Philadelphia, addressed the Society on *The Importance of "Looking Up"*. He presented the common anal, rectal and sigmoidal diseases seen by the general practitioner and discussed their diagnosis and treatment. Brief commentaries on the topic were offered by Dr. George Becker, Paterson, Dr. Robert Barbour, former professor of surgery, Long Island University Medical School, Dr. A. Alfred Podell, attending proctologist, Monmouth Memorial Hospital, Dr. Thomas Andrews and Dr. Harry Brindle.

A short business meeting followed. Elected to full membership were Dr. Abraham S. Collis of Long Branch and Dr. Edward E. Banta of Red Bank.

Dr. Norman Nathanson reporting for the Public Health Committee, presented plans for Public Health Week.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Administration Building on September 21, at 9:00 p. m., with the president, Dr. J. Allen Yager, presiding.

The following were elected to membership: Active — Drs. Laura Ehrlich Morrow, John R. Gannon, Harold Nimaroff, Bernard D. Pinck of Passaic; Stanley T. Jurewicz, Charles A. Nuzzolo of Paterson; Anthony E. Abramo, Midland Park; Joseph G. Varhol, Clifton. Associates — Drs. George K. Tweddel, Jr., Edward F. Vander Bush, Emil P. Novak, Murray G. Urie, Herbert Farber, Gerald I. Kurtz of Paterson; Peter H. Shershin, William V. Young of Clifton; Paul De R. Kolisch, Glen Rock; William J. Muster, Ridgewood; Richard S. Colfax, Pompton Lakes.

At the request of Dr. Irving Okin, chairman of the Public Health Week Committee, a sum not to exceed $1500 was appropriated for Public Health Week expenses.

Dr. Yager introduced William Bryant Rawls, M.D., chief of Arthritis Clinic, Polyclinic Hospital, who spoke on "An Evaluation of Present-day Therapy in Rheumatoid Arthritis". The paper was illustrated by lantern slides and was well received.

WARREN COUNTY

Joseph C. Humbert, M.D., Reporter

Election of officers featured the annual meeting of the *Warren County Medical Society*, held October 19, at Warren Hospital, Phillipsburg. With Dr. Frank Bartolini presiding, the following were unanimously elected to assume office in June, 1949: *President*, Dr. Joseph C. Humbert; *Vice-President*, Dr. T. H. Spillane; *Secretary*, Dr. Raymond Cooper; *Treasurer*, Dr. Walter A. Boquist; *Censor*, Dr. H. Baldauf; *Delegate*, Dr. Ralph M. Buchanan; *Reporter*, Dr. Louis Genninger.

Drs. Charles E. Miller, of Hackettstown, and John J. Macdonald of Belvidere were elected to membership.

After a warm discussion, during which it appeared a majority of those present felt the society was too small to organize an elaborate program, it was voted not to partlcipate in the State Public Health Week.

Belleving that the present system of listing specialists in the classified section of the Easton-Phillipsburg Telephone Book needed revision, a committee consisting of Drs. H. J. Adler and Alexander Bertland was appointed to confer with the Secretary of the Northampton County (Penna.) Medical Society.

Other business consisted of the presentation and approval of the Treasurer's Report, motions to hire a paid secretary's assistant, and to write a letter of recommendation for Dr. Eugene Cioffi to Glen Gardner Sanitarium, both of which passed, and a review of the so far fruitless correspondence with various agencies regarding the Easton Hospital situation.

NEW JERSEY ORTHOPAEDIC SOCIETY

R. R. Goldenberg, M.D., Secretary

The third annual meeting of the *New Jersey Orthopaedic Society* was held in Paterson on October 9. The following officers were elected:

President—Harold W. Smith, M.D.
Vice-President—Nicholas Ransohoff, M.D.
Secretary—R. R. Goldenberg, M.D.
Treasurer—Roy Ciccone, M.D.

The following scientific program was presented:

Osteomyelitis of the spine—Sidney Brooks, M.D., by invitation;

Eosinophilic granuloma—Vincent Guidice, M.D., by invitation;

Bone tumors—R. R. Goldenberg, M.D.;

Treatment of traumatic amputation of the fingers —Roy R. Ciccone, M.D.;

Bilateral rupture of quadriceps muscles—Eugene L. Wild, M.D., by invitation;

Capsulectomy for flexion contracture of the elbow —J. C. Warburton, M.D., by invitation;

Avulsion of distal biceps brachii tendon—R. R. Goldenberg, M.D.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Robert B. Walker, President

We as doctors' wives have a personal obligation to increase our membership of 1288 to that of the State Medical Society, an approximate 5129. If we are to disseminate health information throughout our state, the Auxiliary must continue to grow and exert its influence. This can only be accomplished by energized county auxiliaries with full membership. We need the additional strength of new members.

The history of an organization, if it is to be a record of progress and high achievements, depends on the ideals embodied in the purpose of the organization, and the efficient united efforts of its leaders and members in the promotion of its plans.

The quality of our membership should be such that we may be able to influence other women's organizations for the service of the community and the promotion of public health. In maintaining the democracy of medicine the individual physician's wife as a central pivot for expansion should share the responsibility of increasing membership in her county.

While the basic purpose of the Auxiliary and its objectives remain the same after twenty-one years of service to the medical profession our possibilities and scopes have enlarged. We are directly under the supervision of the Medical Society, therefore, the distributing of health information should be in our hands rather than in the hands of lay organizations because health information should be given through the medical profession so that there may be rational control of what the public thinks and does in health activities.

May I urge you to exercise your privilege of membership in the Auxiliary by assisting your county in adding the names of those nonmembers to your roster and thus fulfill the fifth point of our program, namely, "to increase membership until one-hundred per cent has been attained".

STATE AND COUNTY MEETINGS

STATE—October 11, 1948—Trenton.

Mrs. Robert B. Walker, president, presided at the fall meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey and forty-three members were present. Mrs. David B. Allman, Convention chairman, announced the Annual Convention for April 26, 27 and 28, 1949, at the Ambassador Hotel, Atlantic City. Rates for single rooms $6-$10 and double rooms $9-$14. Reservations may be made only through Mrs. Edith Madden of the Medical Society Headquarters. State committee chairmen and county presidents gave their reports. A report of the special committee on dues for newly organized counties was given by Mrs. Allman. She reported that new Auxiliaries shall have the privileges of the other Auxiliaries when charter members pay their dues. Mrs. J. Howard Hornberger is the newly appointed historian. The speaker of the afternoon was Mrs. Margaret Zealand, a representative from the State Department of Health, at Trenton. She stated the State Department was ready to help with health exhibits. During her talk on "Foods, Fads and Fashions", she stressed the importance of breakfast to children and adults. She further stated that "The Auxiliary should spread sound scientific information to answer the faddists and obtain authentic information by writing to the National Research Council and the A.M.A."

ATLANTIC—October 8, 1948, at the Traymore, Atlantic City.

Mrs. Harry Subin, president, introduced Mrs. Robert Walker, state president, and Mrs. Norman Nathanson, president-elect to the group. Mrs. Walker gave a brief history of the founding of the Auxiliary. Mrs. Clarence B. Whims, chairman of the ways and means committee, announced a tentative date for the formal dance for the benefit of the Student Nurses Scholarship Fund.

CAMDEN—October 5, 1948, at the Haddon Fortnightly Club, Haddonfield.

Mrs. Harold D. Barnshaw, president, welcomed the guests and members. Mrs. Karl S. Russell, public relations chairman, announced November 16, as the date for the Public Health Meeting. Mrs. Harold K. Eynon, program chairman, presented as honored guest and speaker, Mrs. Robert Walker, who gave a most interesting talk on the Auxiliary. The program also featured reports of chairmen of standing committees. After the program was completed, tea was served by Mrs. Kenneth B. MacAlpine and her committee.

HUDSON—October 6, 1948, at the Y. W. C. A. Building, Jersey City.

Mrs. William Gleeson, president, greeted the members. Plans to institute a new membership

drive were discussed and formulated. Mrs. John Mackin was appointed chairman with Mrs. Timothy Gerne, co-chairman. Two appointments were announced: Mrs. Fred Sachs to serve as public relations chairman and Mrs. James Tsucalas as chairman of the safety committee. Arrangements are under way for a dinner dance to be held in November with Mrs. A. Albert Lepis in charge. The afternoon's program consisted of a talk "Safety in the Home", given by Mrs. Hornaday of the New Jersey State Safety Council.

PASSAIC—October 18, 1948, at the Mayfair Farms, in West Orange.

Mrs. Peter J. DeBell, president, presided. Mrs. Theodore K. Graham, program chairman, introduced Mr. George Duncan Crookes a member of the staff of F. Schumacker & Co., who gave a delightful and interesting talk on "Fabrics, the Key to Successful Decoration". Mr. Crookes' talk was illustrated with a superb collection of samples, including rare historic documents which have inspired many of our newest fabrics. Mrs. A. K. Markel will be chairman of the annual Doctor's Dance to be held in December.

UNION—September 21, 1948, at Hillside.

Following a short business meeting, a tea was held at the home of the president, Mrs. William O. Wuester. Mrs. Graham Newbury, Cranford, who heads the newly formed committee on Student Nurse Scholarship Loans reported the present plan is to give one scholarship loan a year to a Union County resident who meets the requirements—primarily need. Seventy members and guests attended and thirteen new members joined the Auxiliary. Mrs. Walter Phelan, Elizabeth, and Mrs. Elton Lance, Rahway, poured.

A lecture on socialized medicine was presented by the Woman's Auxiliary to the Union County Medical Society, on October 6. The meeting was held at the Winfield Scott Hotel in Elizabeth and was open to the general public. There was no admission charge. Considerable publicity had been obtained in the county newspapers and an interested crowd turned out to hear Mr. Arthur Conrad, who is the associate administrator of the National Physicians Committee for the Extension of Medical Service. Mr. Conrad discussed particularly *Socialized Medicine—The Opening Wedge towards a Collectivist Society.* Mr. Conrad was introduced by Mrs. Bertram Sauerbrun, program chairman. Mrs. William Wuester, president, presided at the question period which followed the lecture.

WARREN—September 21, 1948, at Morrie's Acres in Phillipsburg.

Mrs. Frank Bartolini presided over the meeting that followed a luncheon. Announcement that the Auxiliary would make plans for public health week in November was made by Mrs. William Varney, chairman of public relations. A program for the coming year was outlined. Mrs. Joseph Shevitz will act as hostess for the October meeting.

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BOOK REVIEWS

The Bellevue Story. By Page Cooper. Pp. 277, no illustrations. T. Y. Crowell Company, New York, 1948. ($3.)

It seems incredible that any publisher would release a history of a 300-year old hospital, without including anywhere in the volume a single illustration. Yet here we are offered 277 pages on pulp paper recounting in anecdotal fashion the high spots of one of the premier hospitals of the country. Miss Cooper is particularly sensitive to the many dramatic incidents that have enlivened the history of Bellevue, and she can describe in vivid word portraits the leading characters of the Bellevue story.

The book traces Bellevue from the 6-bed infirmary of the 1658 almshouse to the 3000 bed medical center of today. Some of the greatest names in medicine parade through the pages—David Hosack and John Erdmann, Dr. McBurney and Austin Flint, Jacobi, and Welch, Willard Parker and Bela Schick, Wyckoff and Gettler, Dalafied and Holt, Valentine Mott and James Alexander Miller—all drawn with wisdom and wit. Occasional errors bother the reader—thus, homeopathy is the creation of Hahnemann, not, as Miss Cooper says, of Haldeman. And she refers to a Veterans Hospital as a Veteran's "Facility", a term which was abandoned years ago. Except for these rare errors, and for the total absence of illustrations, the volume is a pleasant one, guaranteed to give any Bellevue alumnus a glow of pride in the spirit and achievements of his alma mater.

Henry A. Davidson, M.D.

Office Treatment of the Eye. By Elias Selinger, M.D. Pp. 542, with 67 illustrations. Chicago. The Year Book Publishers, 1947. ($3.75).

The material in this book is largely the viewpoint of the author. The subject matter covers office and home procedures useful in the practice of ophthalmology. An important feature is the minute detail with which simple procedures such as removal of a foreign body in the cornea, are described. Even to the experienced ophthalmologist much will be found of interest.

A brief description of the clinical picture and discussion of etiology is included under all the headings. All the most recent drugs and anti-biotics are listed where they have been found to be useful.

This book is highly readable and is a worthwhile addition to any doctor's library.

Morris Harris, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **November, 1948** **No. 11**

THE LAG between knowledge and practice is nowhere better illustrated than in the slowness with which general hospitals have instituted the routine chest X-ray examination of all patients at the time of admission. Yet everyone benefits when this is done—the patient, the professional staff, the hospital employees and the community.

X-RAY PROGRAMS IN GENERAL HOSPITALS

Hospitals should institute X-ray examinations of all admissions. The hospital can render this health service, which is essential for the protection of the public health, better than any other agency.

Chest X-ray surveys can be conducted in hospitals much more easily, economically, and quickly than in other groups. Hospitals also offer ideal opportunities for intensive case-finding. Most of the entering patients are free from tuberculosis, but some will have tuberculosis in its earliest stages and a few previously undiagnosed advanced cases will be found.

In 1946, more than 15,000,000 people—more than 10 per cent of the total population—spent some time as patients in hospitals. This means that a new hospital patient was admitted every two seconds. In the same year nearly 2,000,000 new citizens were born in the 7000 hospitals of this country. Millions more are treated as outpatients in the clinics. Each patient admitted should have the benefit of a chest X-ray.

Tuberculosis is often considered a disease of youth. Contrary to this opinion, however, mortality figures in the United States show the highest death rate from tuberculosis occurring in the 70-year age group. Too few persons—even among those engaged in tuberculosis control—recognize the fact that the phenomenal decrease in the death rate among younger persons has not been accompanied by a similar decline among the aged. Yet the trend in the death rate from tuberculosis increases with each five-year age group from 15 to 75. Tuberculosis among the elderly is frequently masked by the infirmities of age. It is often difficult to interest elderly people in a physical examination. These same elderly people, however, make up a large proportion of admissions to general hospitals. Here is the opportunity to begin work on the difficult and enormous problem of finding tuberculosis among the elderly.

A general hospital has three compelling reasons for taking X-rays of all patients and personnel. First, to serve its community as a case-finding center. Second, to protect its employees from the spread of tuberculosis infection by patients. Third, to protect the patients from contracting tuberculosis infection from other patients or from the personnel.

Whenever a patient with unrecognized open tuberculosis is admitted to a hospital he becomes a menace to some of the personnel in the institution. This hazard can be avoided only by routine chest X-ray examinations made on admission. Otherwise proper precautions against contagion cannot be taken.

Nurses entering training should and do have careful physical examinations and chest X-rays to assure that they are free of tuberculosis. During training, however, many contract infection from hospital patients. The only preventive for this tragic accident is admission X-raying of every patient.

With a thorough case-finding procedure among personnel and routine X-raying of all admissions there is less danger of tuberculosis infection being spread in the hospital. The danger arises within the hospital, not from accepting tuberculous patients, but from hospitalizing them with their tuberculosis unrecognized. This has been, and still is, the practice in many hospitals. When patients are known

to be tuberculous, most of the acute danger of contagion can be avoided. Admission X-rays usually tell us who these patients are so that adequate isolation can be provided.

Hospital admission X-rays are a public benefit. By this means, the disease can be discovered in a population group which cannot otherwise be screened by general or industrial X-ray surveys—the mother, the housewife, the maid, the self-employed and, as pointed out before, the aged. Of the fifteen million persons entering general hospitals in 1946, two million were obstetrical patients. Women of child-bearing age have a high tuberculosis mortality and often are not included in mass X-ray examinations.

Early and accurate diagnosis of chest conditions is always an aid to the physician. Even if disease is not discovered, it guards against the dangers of incomplete diagnosis.

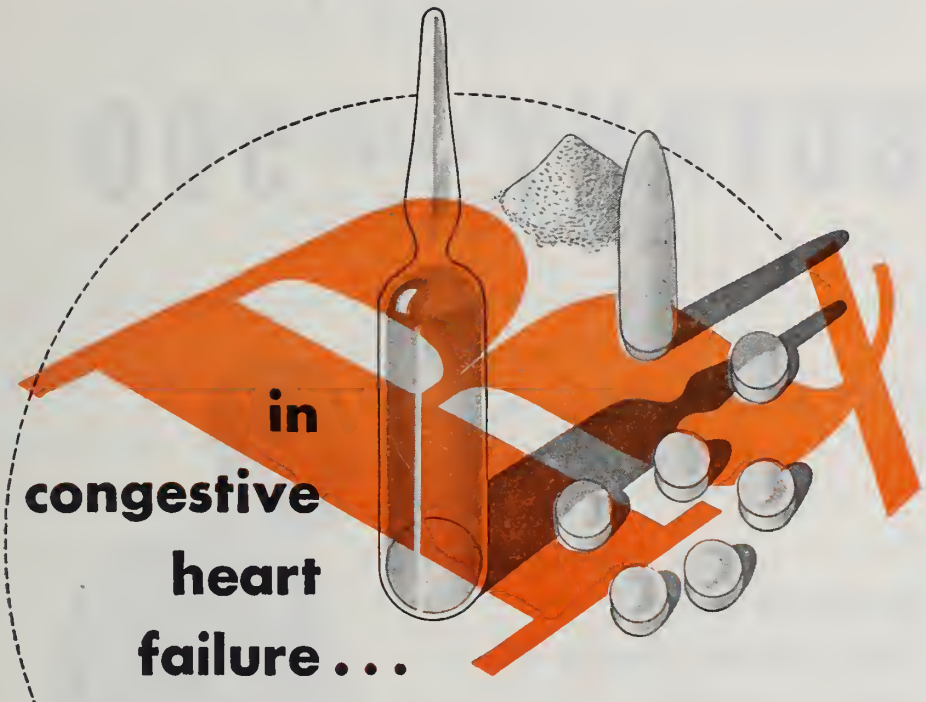
The program of hospital admission X-rays is approved by the American College of Radiology as a screening device; in no way does it supplant regular X-ray examinations. Chest X-rays give impetus to accurate diagnosis by the staff, interns, and house staffs and complete the hospital records of the patients admitted. The X-ray makes a graphic addition to the record; in subsequent illness it may be consulted by the family physician if he suspects aggravation of a previously existing lesion.

What We Expect from X-ray Programs in General Hospitals, F. M. Meixner, M.D., National Tuberculosis Association Transactions, 1947.

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SEARLE

Research in the Service of Medicine

1. Orgain, E. S.: The Treatment of Congestive Heart Failure, North Corolina M. J. 8:125 (March) 1947.

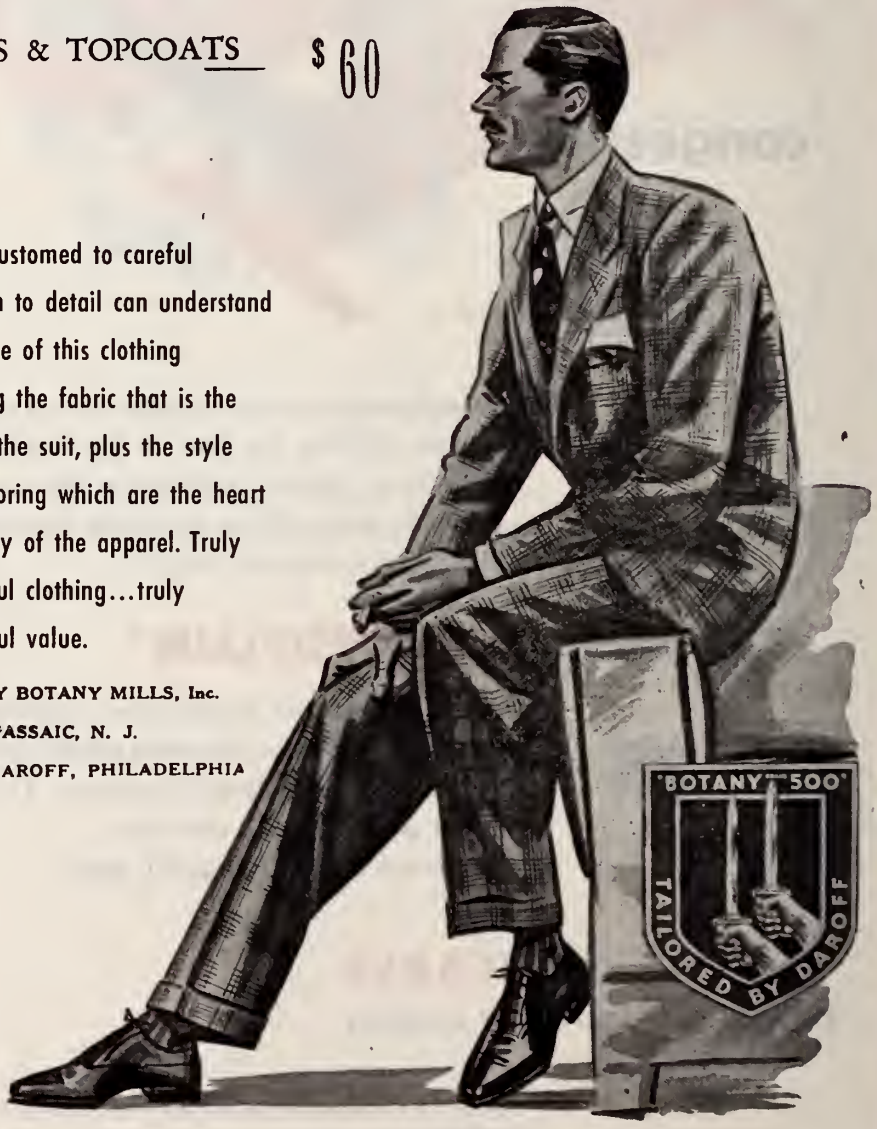
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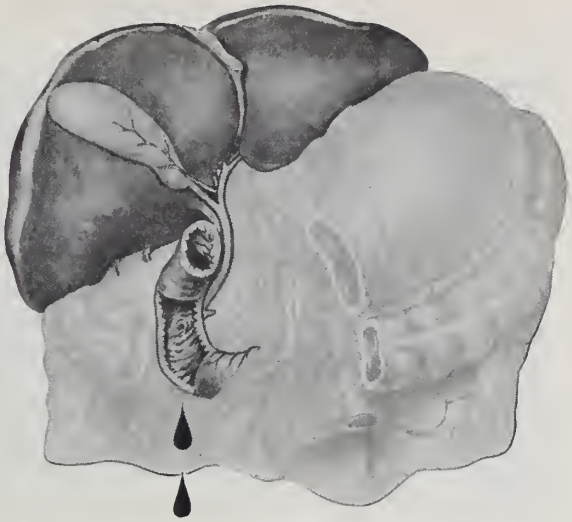
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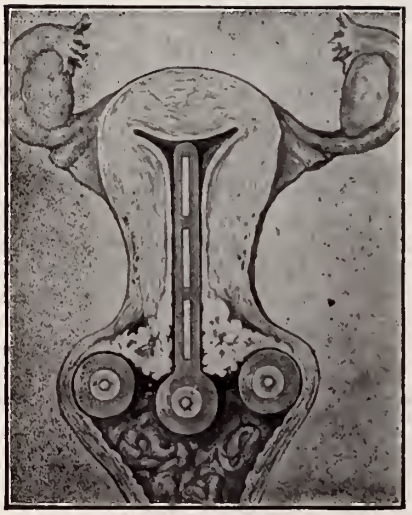
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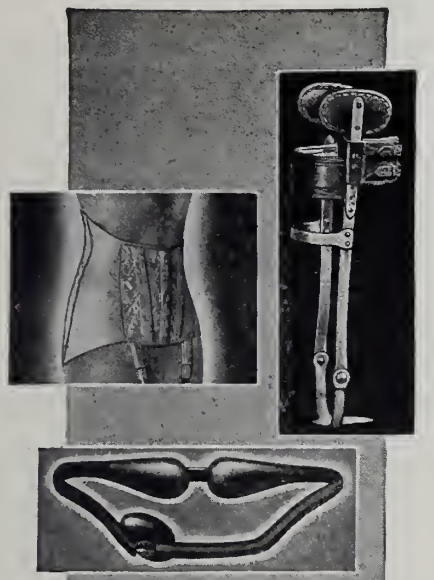
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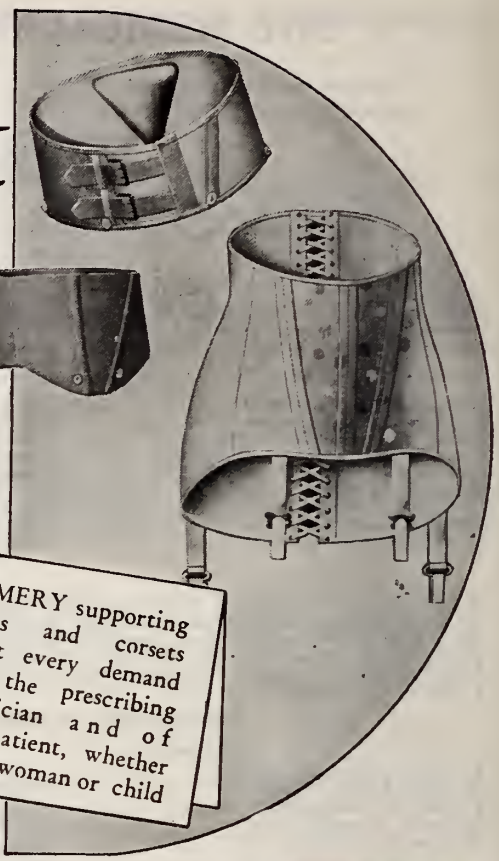
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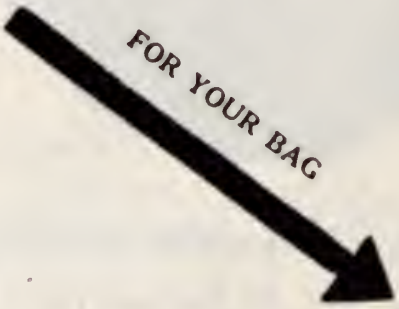
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1. Lennox, W. C. (1947), Tridione in the Treatment of Epilepsy, J. Amer. Med. Assn., 134:138, May 10. 2. Merritt, H. H. (1947), Recent Advances In the Treatment of Epilepsy, with Particular Emphasis on the Use of Tridione, Arch. Neurol. & Psychiat., 57:130, Jan. 3. Gibbs, F. A. (1947), New Drugs of Value in the Treatment of Epilepsy, Annals Int. Med., 27:548, Oct. 4. Fetterman, J. L., and Weil, A. A. (1947), Practical Aspects of Epilepsy (with special consideration of epilepsy in children), Med. Clin. N. America, 31:1273, Sept. 5. Liebert, E. (1947), Treatment of Neurological Disorders with Tridione, Ill. Med. J., 91:311, June.

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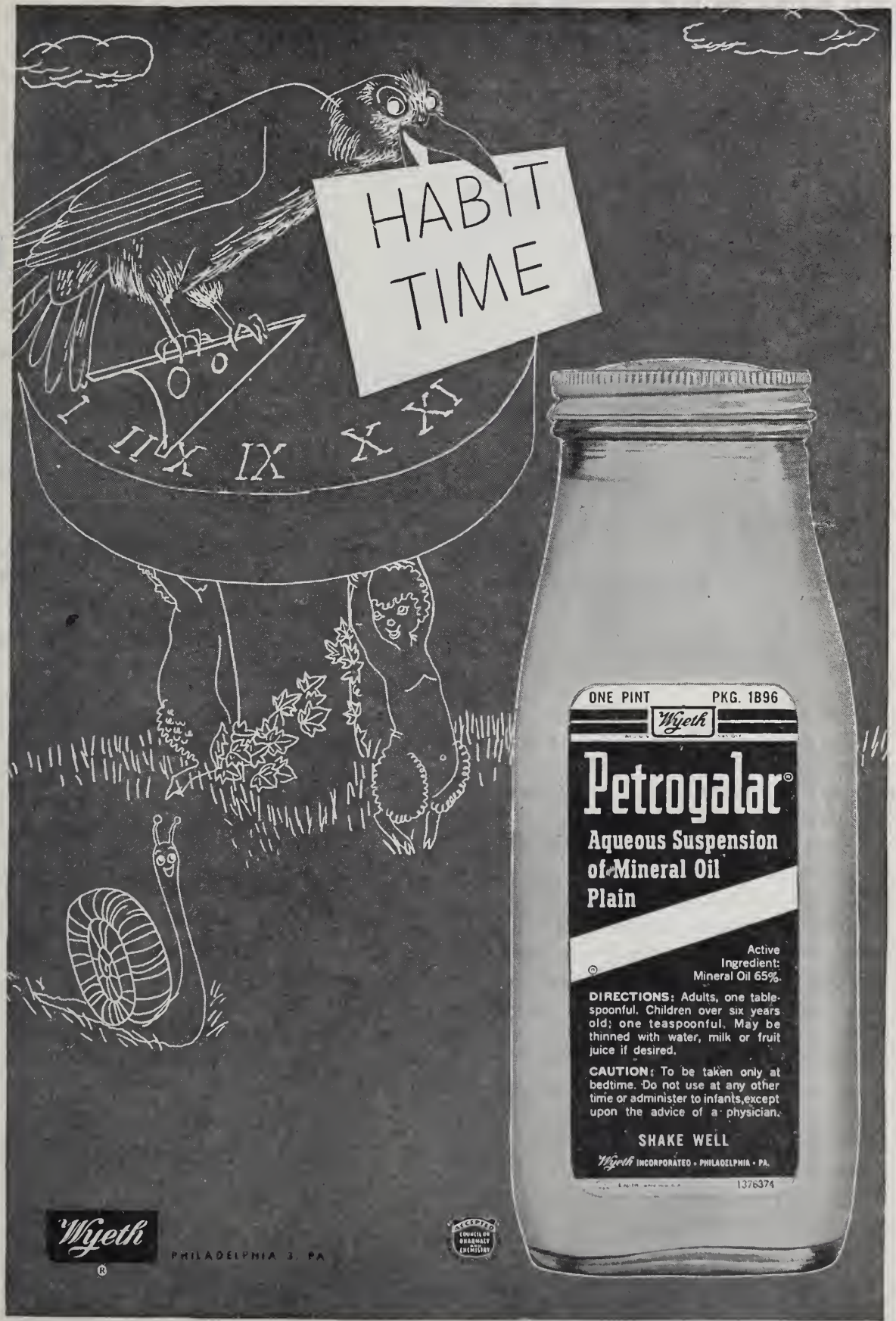
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** As printed in American Heart Journal, Vol. 29, No. 1, Pages 44-61, January, 1945.*

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THE EMPIRE STATE'S CONTRIBUTION TO THE MEDICAL PROFESSION

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ALFALFA SILAGE — 13 lbs.



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3. Salt . . . . . 0.2 lbs.
4. Soybean Meal 0.5 lbs.
5. Gluten Feed 0.5 lbs.
6. Linseed Meal 0.1 lb.
7. Distillers Grain 0.5 lb.
8. Brewers Grain 0.5 lb.
9. Bran . . . . . 1.5 lbs.
10. Oats . . . . . 2. lbs.
11. Corn . . . . . 1.5 lbs.
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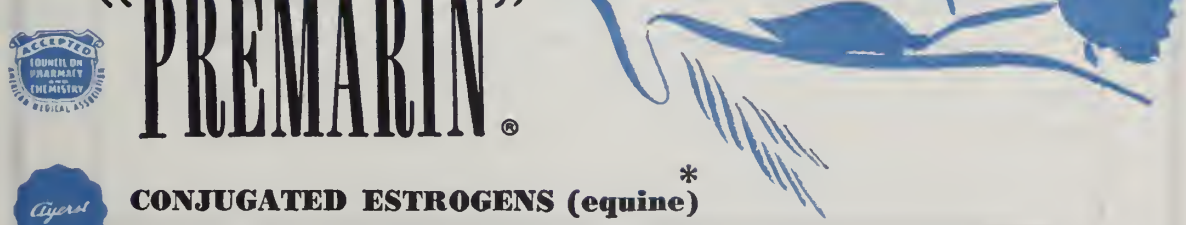


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*Philip Lewin, M. D., F.A.C.S.
Backache and Sciatic Neuritis,
Chapter XXXIX, Page 580
Published 1943 by Lea & Febiger, Philadelphia

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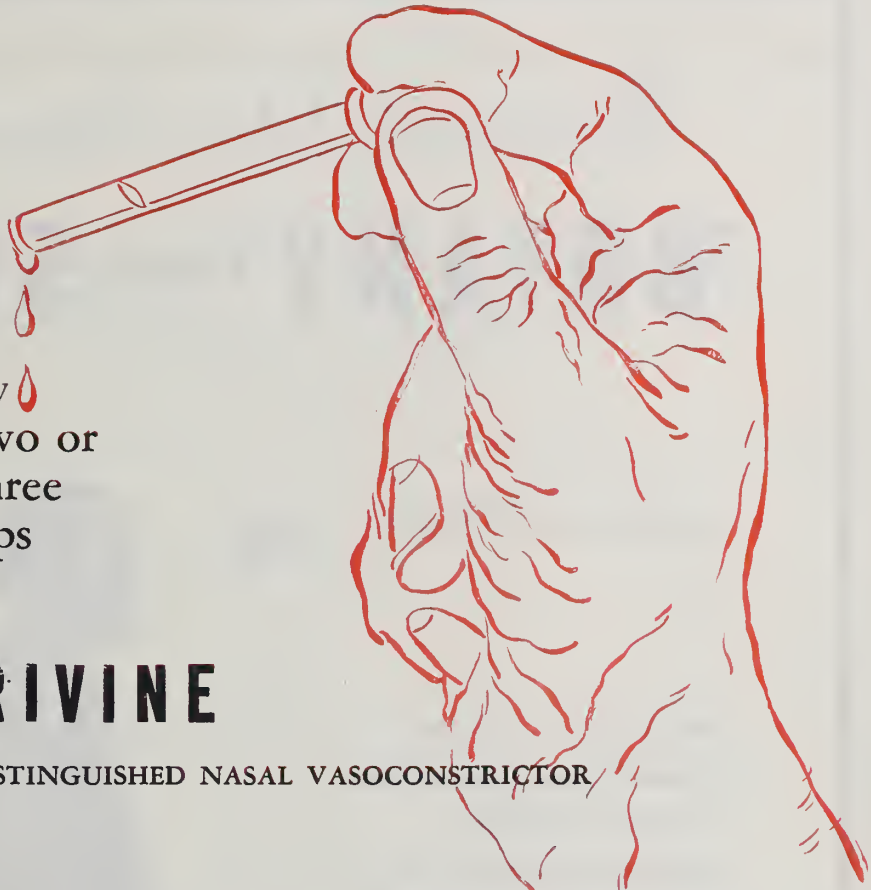


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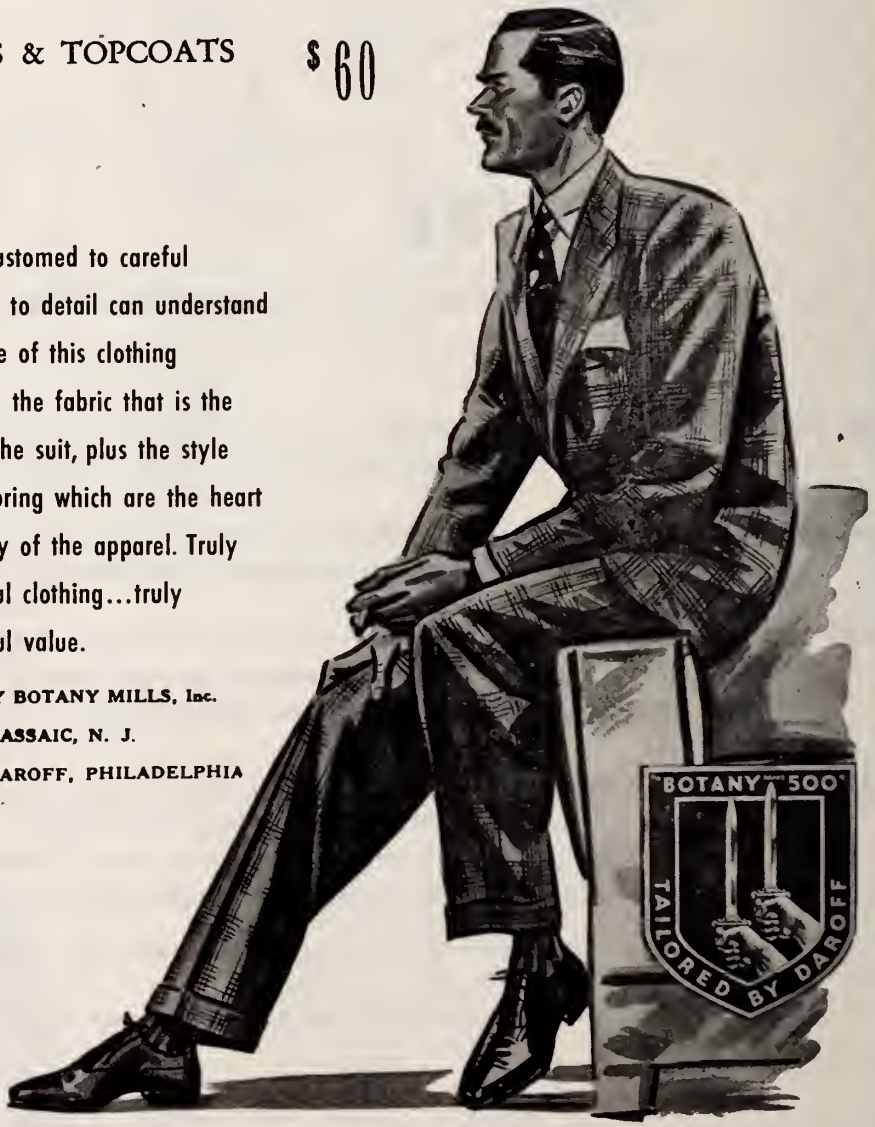
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OF
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EVEN NIGHTINGALES MUST EAT

The Diamond Jubilee of trained nursing in America, marking the seventy-fifth anniversary of the profession, was recently celebrated throughout the country.

It should serve to remind us that in the nation's war to prevent and conquer illness, the well-prepared white-capped registered nurse is the Indispensable Woman.

When she takes a temperature or pulse, or attends us with cool efficiency at the hospital, we are getting the help of someone who has gone through fifteen years of schooling, including three years of professional nursing education. She must also have good health, great physical stamina and unusual strength of character. She could not perform her vital task in the modern world without patience, devotion, loyalty and self-sacrifice.

All this sounds as if the trained nurse is a very special kind of woman, a true heir of Florence Nightingale. She is, but even Florence Nightingales must eat, and it is a disquieting fact that the highly trained women who make up our nursing profession, and on whom America's health program so heavily leans, are condemned to low salaries, long hours and split shifts.

Institutional nurses average only forty-five dollars a week. About half of the country's institutional nurses work a forty-eight hour week, and one-fourth of them more than fifty hours a week. Few nurses receive overtime pay and most of them are not protected by old age and unemployment insurance. Low wages and long hours are to a large extent responsible for the acute nursing shortage which America faces today.

This shortage is no fault of the nurses. Actually, this country has more professional, registered nurses than ever before. But the demand for nursing care has increased tremendously in recent years, far outstripping the supply. To make up

this deficiency which endangers the nation's health, thousands of new nurses must be recruited. These can be attracted only by improving the economic position of nurses, by granting the trained nurse the status, treatment and compensation commonly accorded to members of other professions.

NOT MUCH LATER THAN TOMORROW

If the recent election proved anything, it drove home the fact that the pre-Roosevelt social climate in the United States is as dead as the Palaeozoic Age. Reaction to the extreme right, milk and water expediency at dead center, and demagogic communism on the extreme left—all were roundly rejected in favor of a strictly indigenous sort of American progressivism, that is certainly well to the left of center.

The meaning of the election, in terms of the hopes and aspirations of the voting majority, is to be discovered not so much in the election of Mr. Truman, as in what the voters did about the Senate and the House of Representatives. With amazing consistency, in every clime and sector of the land, our sovereign fellow citizens flushed out the backward looking and rewarded men and women whose eyes are set in the front of their heads—regardless of mere party labels.

It will be fatal should we fail to recognize the fact that our American society is in what may be only the early or middle stages of a profound social revolution. World War II served temporarily to slow the pace of social change, but it quickened its urgency and sharpened its sense of direction. American society is on the march, not toward communism, not even perhaps, toward any classical form of socialism, but certainly towards a re-defined, newly incarnated "American Way of Life".

Every real American who puts freedom, tolerance, and the Bill of Rights at the top of his list of values to be bled for, every real American will want to play more than a passive part in defending those values. He will determine that, come what may in the realm of economic and social reform, basic freedom, essential self-determination, and the subservience of the State to the citizen, must be preserved.

What does the resurgence of the Neo-New Deal portend for the American physician?

There can be no question but that our national government will assume new responsibilities in providing better health protection and readier access to good medical care, especially for the indigent and lower income people. The majority party is firmly committed to a comprehensive national health program. It has the votes to deliver and its leader, in the light of his spectacular triumph, is certain to demand that such a program be enacted.

It would be fatal, in our opinion, if the medical profession were to try to obstruct such a program in toto, or were to refuse to counsel and advise our government in formulating a sound program of health and medical reform. The profession has been at great pains in recent years to improve its "public relations". We have sought, with a remarkable degree of success, to demonstrate our understanding and concern for the needs of the people. We have manifested our desire to work in partnership with government and with every civic agency in promoting better health protection and in making good medical care available to everyone.

Through these sincere efforts, we have recovered all the damages wrought upon our public esteem by the attacks of the earlier New Dealers, plus our own blundering in the years when most medical

leaders still dozed in the land of the lotus. Today, most people will agree, the medical profession stands at the top of its prestige. No longer are the labels of "obstructionists", "anti-social reactionaries", or "merchants of medicine" pinned upon the doctors. Medical leadership in recent years has not lagged behind; if anything, it has been a few steps ahead of its constituency.

But all this hard-won public confidence, our most precious and most fragile asset, may be lost in a week or a day should we fail to judge aright the tempo of the times, the temper of the American people, and the broader meaning of this election.

Equally fatal would be a resort to the threadbare tactic of vituperation. The people have not elected a single communist—well, not more than one—to any office in the federal establishment. Nor are the people who voted for Mr. Truman communists. Mr. Wallace saw to that. It will not serve us well to rant about communists or communist trends, or to look for the hand of Moscow in every proposal to alter the status quo in medical affairs.

American doctors are American citizens. They happen to be the custodians of a very special art which is recognized by all Americans as a necessity of life—a public utility. They also happen to be particularly sensitive to the need of personal freedom, of professional independence, for the satisfactory performance of their craft. It will be the special responsibility of American doctors in the months immediately ahead to render invaluable counsel to the people of this country, to the end that the reasonable purposes of the people may be realized while maintaining all that is good and essential in our medical heritage. An inevitable demand for medical statesmanship will be upon us not much later than tomorrow.

NURSE RECRUITMENT AND THE FAMILY DOCTOR

While he rarely visualizes himself as a part-time recruiting officer, the family doctor is, none the less, in a key position to help promote the campaign stressing nursing as a desirable career for young women. How the medical profession will benefit by an expansion of the present reservoir of nurses, is obvious.

Many of the girls who become interested in nursing as a career, through the current promotional campaign, will certainly turn for vocational advice, to their family physicians. What the doctor says about nursing is incalculably important to the success of the campaign.

The doctor can honestly tell each inquirer that the well trained graduate nurse will continue to have innumerable vocational opportunities. And he can help the recruiting campaign in other ways too. For instance, he can help by

1. Offering to speak on the opportunities and advantages of professional nursing at special local recruitment programs.
2. Permitting displays (posters, special literature, etc.) to be set up in the waiting room of his office.
3. Pointing up the advantages of professional nursing among patients.
4. Discussing the opportunities and advantages of nursing among civic groups in which he holds membership.
5. Informing local hospital training schools about all prospective candidates he might learn of through conversation with patients, friends, etc.

Such activities represent triple-barreled service. They help the public which is now in such acute need for nurses' services; they help the medical practitioner by recruiting more well-trained assistants; and they help the young women concerned by setting them on a dignified, gratifying and remunerative career.

ORIGINAL ARTICLES

THE ANTICOAGULANT TREATMENT OF VENOUS THROMBOSIS *

Arthur J. D'Alessandro, M.D., Newark, N. J.

Thrombo-embolism is of interest to any clinician who cares for a middle or advanced-age patient with a confining illness. A review of 370 autopsies, with emboli showed that 40 per cent were postoperative, 60 per cent medical, 30 per cent of these cardiacs.

The incidence of venous thrombosis is approximately one per cent following all major surgical procedures,[2] two per cent following all laparotomies [3] and three per cent following laparotomies [4] on women. The mortality from venous thrombosis alone (invariably due to pulmonary embolism [2]) is 20 per cent. Pulmonary embolism [5] is responsible for about six per cent of all deaths after major surgery and approximately 0.2 per cent of all surgical patients.[6] At least 10 per cent of all autopsies [7] show some evidence of pulmonary emboli.[8] Whether or not your own impressions or experience conform with these figures, you must remember that to the unfortunate victim and family the incidence is 100 per cent. The tragic finality of a sudden massive pulmonary embolism in a surgical patient preparing to leave the hospital in the second week postoperatively—a picture familiar to all surgeons—cannot be expressed in figures. Nor can we reduce to statistics the disability, discomfort, economic loss and psychic trauma due to the non-fatal complications of thrombophlebitis such as chronic edema, infected ulcers, skin disorders and other postphlebitic sequelae.[8]

As the result of early exercises [9] and ambulation,[10] the incidence of venous thrombosis has been reduced to 0.6 per cent or by approximately one-third,[5] although the mortality in these cases of thrombosis remains 20 per cent.

A pathologic and clinical distinction is made between the much more common and serious phlebothrombosis [11] and the far less common and clinically less serious thrombo-phlebitis.[12] As the name implies, in thrombo-phlebitis the emphasis is on the inflammatory reaction as the inciting factor in the production of a thrombosis, which is generally so fixed to the vessel wall that emboli are rarely released. In phlebothrombosis the emphasis is on the thrombus itself, regardless of etiology. This thrombus acts as a foreign body producing an inflammatory reaction upon which depends the absence or severity of clinical symptoms and signs shown below. As a rule, the more silent and insidious the thrombotic episode, the greater the danger of a massive fatal pulmonary embolus.

SIGNIFICANT SIGNS IN VENOUS THROMBOSIS

1. Tenderness or pain over calf muscles, malleoli or plantar surfaces.
2. Pain on dorsiflexion of the foot with leg extended (Homan's sign).
3. Swelling of one or both legs.
4. Unexplained rise in pulse or temperature—particularly after the third day postoperatively.
5. Pains in chest (emboli).
6. Apprehension, pallor, nervousness and uneasiness.
7. Cyanosis of the legs.
8. Temperature differences in the lower extremities.
9. Venography—(not very practical in average patient).
10. Decreased heparin tolerance test.

It is one of the paradoxes of nature that the healing qualities of thrombosis, so essential to any surgery, should also kill by embolism. Increased coagulability of blood is no more desirable than decreased coagulability. The rationale of anticoagulant therapy is an attempt to maintain blood by appropriate measures, in a safety or surgical zone of coagulability.

Theoretically, complete incoagulability of blood (and not merely the prolongation of the clotting mechanism *in vitro)* would be desirable to prevent venous thrombosis. Actually and practically, however, mere prolongation is adequate as has been conclusively demonstrated [13] both clinically and experimentally.

PATHOGENESIS

Best [14] has clearly described the pathogenesis of thrombosis, emphasizing the role of platelets. He pictured platelets accumulating at the injured intima of a blood vessel and forming a mass or white thrombus. Fibrin is subse-

* Read before the Surgical Section of the Annual Meeting of The Medical Society of New Jersey, Atlantic City, April 27, 1948.

quently deposited within and around this clump of platelets by virtue of the clotting mechanism initiated by these altered platelets. Other cellular elements of the blood then become enmeshed in this network of fibrin and this mixed thrombus grows accordingly downstream in the direction of blood flow. Once formed, a thrombus acts as a foreign body by stimulating production of thromboplastin and causes further growth of the red thrombus by apposition.

In 1882 Bizzozero first watched the gradual accumulation of platelets at the site of a damaged vessel wall and in 1885, Eberth and Shimmelbusch showed that when blood flow was slowed, the platelets migrate to the periphery of the blood stream before attaching themselves to the wall.

The three outstanding factors conducive to the mechanism of thrombosis [15] are (1) venous stasis, (2) injury to the intima of a blood vessel and (3) increased coagulability of the blood. The many less important (yet significant) predisposing factors are listed below. No one factor adequately accounts for thrombosis and it is likely that more than one factor is responsible in any one case. The more derangements are present, however, the greater the likelihood of venous thrombosis.

PRECIPITATING FACTORS IN VENOUS THROMBOSIS

1. Injury to intima of vein.
2. Diminished venous blood flow.
3. Increased blood coagulability.

PREDISPOSING FACTORS IN VENOUS THROMBOSIS

1. Age.
2. Immobilization.
3. Constitutional diathesis—"Thrombophiles".
4. Obesity.
5. Lowered metabolism.
6. Chronic debilitating diseases e.g. cancer or tuberculosis.
7. Anemias.
8. Increased blood viscosity e. g. dehydration, polycythemia.
9. Systemic infections.
10. Circulatory disturbances.
11. Pregnancy.
12. Trauma.
13. Surgery (especially of abdomen or pelvis).
14. Climate and atmospheric conditions?

About ninety-five per cent of all thrombi arise in the deep veins of the lower extremities especially the foot and leg. Normally these veins empty in 20 to 30 seconds. After operation, however, the emptying is delayed two to four minutes in 82 per cent [17] of patients. This retardation seems to manifest itself on the second postoperative day [16] and persists as long as the patient remains bed-ridden.[18]

The role of damaged intima in the production of thrombi has been amply demonstrated both clinically and experimentally. In fact Frykholm [19] has postulated his theory of venous thrombosis on the damage to the intima of veins resulting from collapsed veins, and has recommended that the *head of the bed be elevated* on all postoperative patients to keep the veins of the extremities distended. Most clinicians [20] seem to favor a slight Trendelenberg posture with the *lower extremities elevated.*

It seems to me that there are merits to both positions. A logical and practical solution would be to place all postoperative patients in Saunders oscillating beds until patients become truly ambulatory. This passive stimulus to circulation is especially important in the immedate postoperative state of deep narcosis from anesthesia and hypnotics. Certainly the use of the kneebreak in the commonly used Gatch beds should be forbidden on all patients, surgical or otherwise, of 30 years or older.

In the postoperative state, there are changes which favor increased coagulability of the blood. The increase in coagulability [21] of blood begins within 24 hours [22] after operation and may last for a week [23] or more. To what extent any one of the factors below listed accounts for this increased coagulability is open to question. Certainly a highly active trigger enzyme like thromboplastin (which is released in such large quantities into the general circulation as result of tissue damage and platelet destruction consequent to all surgery), must play a highly significant role. Disturbed hemodynamics often approaching shock in the course of an operation must also be an important factor. The initial thrombocytopenia found in the first five days postoperatively followed by a marked thrombocytosis from the sixth to the fourteenth day postoperatively [24] may be due as much to increased platelet agglutination to vessel walls as to destruction of the platelets.[1]

SIGNIFICANT POSTOPERATIVE LABORATORY CHANGES

1. Hemoconcentration (dehydration).
2. Diminished venous blood flow.
3. Diminished blood platelets for first week with abnormal increase second week.

4. Increased platelet cohesiveness.
5. Increased thromboplastin and prothrombin activity.
6. Increased fibrinogen.
7. Reversal of albumin-globulin ratio.

Although most demonstrable changes favoring blood coagulability are at their height near the end of the first week probably the greatest insults to the blood and blood vessels conducive to thrombosis occur on the operating table and immediately postoperatively. The pathology usually arises in a silent and insidious manner manifesting itself explosively in the postoperative period as phlebitis or, worse, as an embolus without clinical evidence of a thrombosis. This occurs [25] in about 40 per cent of cases.[26]

The role of blood platelets in the formation of postoperative thrombosis merits special consideration. An actual thrombocytosis alone is not sufficient for the formation of a thrombus as indicated by some patients with platelet counts of over a million without evidence of thrombosis.[27] A much more significant change is the increased cohesiveness, agglutinability or clumping of platelets due to a change in the electrical surface charge which normally causes repelling. This increased cohesiveness of blood platelets is markedly inhibited by heparin. It may be that when the physiology of blood platelets is more thoroughly unraveled much will have been contributed towards the solution of the thrombosis problem.

MECHANISM OF EMBOLI

Emboli most commonly occur on getting out of bed, or in the act of defecation, coition, straining or lifting. It was shown in the Valsalva experiment (holding one's breath in inspiration and making an expiratory effort with the glottis closed) that during such efforts there is a sharp rise in the venous pressure and blood volume in the legs. With the drop in venous pressure during the next inspiration the decreased venous blood rapidly empties from the peripheral veins, washing with it any loosely attached thrombus.[28] Pulmonary embolism is, as a rule, not a single but a recurrent event over a period of hours or days, leading up to a fatal termination in the event of two-thirds or more of the pulmonary circulation becoming occluded.[29] Probably much more frequently than is realized, smaller emboli are swept into the lungs without arousing any appreciable clinical or pathological reaction.

PREVENTION OF THROMBOSIS

Prophylaxis is the ideal solution to the distressing problem of venous thrombosis. Were it feasible and safe through anticoagulants to inhibit venous thrombosis in all surgical patients, we should have either eliminated the problem of thrombo-embolism or reduced it to an irreducible minimum.

Below, I have listed the present available recommendations for the prevention of venous thrombosis. I especially emphasize *the replacement of all Gatch beds with Saunders oscillating beds* in the immediate postoperative period. Early active exercises and early ambulation have contributed much towards the reduction of thrombosis but they are not the answer to the problem as was originally hoped. In fact in a recent study by Blodgett and Beattie [30] thrombosis was slightly higher in ambulatory patients.

PROPHYLACTIC MEASURES

1. Early active exercises of the lower extremities—especially dorsal and plantar flexion of the feet.
2. Early ambulation.
3. Encourage deep breathing.
4. Avoid tight or constricting dressings.
5. Avoid Fowler's position.
6. Avoid postoperative distention.
7. Forbid massage of legs after confinement to bed for a few days.
8. Adequate fluid intake parenterally and orally.
9. Avoid vasospasm by chilling or tobacco.
10. Minimize tissue trauma with sharp dissection.
11. Avoid trauma to veins in general and extremities in particular.
12. Correct all anemias.
13. Use sedatives sparingly.
14. Use Saunders oscillating beds instead of Gatch beds immediately postoperatively.
15. Chemotherapy and antibiotics in infected cases.
16. Use only pneumatic tourniquets when these are necessary.
17. Compression bandages to legs especially in patients with varicosities.
18. Venous ligations in selected cases.
19. Anticoagulants in selected cases.
20. Sodium thiosulfate (10 cc. of 10 per cent solution I. V. for 3 days postoperatively).
21. Reduce obese patients preoperatively when possible.
22. Thyroid for patients with low metabolic rates.
23. Avoid elective surgery on all cardiacs—especially those with any signs of circulatory insufficiency.
24. *Be "thrombo-embolic-conscious".* — Examine patients daily for signs.

TREATMENT OF THROMBO-EMBOLISM

Below, I have outlined the accepted therapeutic measures for venous thrombosis. Time and space will not permit elaboration on more than the anticoagulant aspect of therapy which is the treatment of choice because it is effective, physiologic, rational, systemic and entails no additional operative procedure or disturbance of a sick patient.

1. Anticoagulants (heparin or dicumarol).
2. Vein ligations (superficial femoral, iliacs, vena cava).
3. Sympathetic ganglia blocks (novocain, bromsalizol).
4. X-ray.
5. Chemotherapy and antibiotics in infected cases.
6. Compression elastic bandages.
7. Antispasmodics — in true thrombophlebitis only. E.g.: papaverine, tetraethylammonium chloride or intravenous novocaine.
8. Analgesics.

HEPARIN

The highly complex organic structure of heparin has defied either analysis or synthesis. The difficult and tedious extraction from cattle liver makes the cost almost prohibitive for the average patient. Another objection to the drug is the necessity of administering it parenterally. Of course neither objection should carry much weight in a patient whose life is threatened by embolism.

The purification of heparin by Charles, Scott,[31] Schmitz, and Fischer in 1933 made possible its widespread clinical application. Heparin is a quick-acting anticoagulant whose effect is lost after three or four hours unless its administration is repeated or continued. It is effective *in vitro* as well as *in vivo*.

The large basophilic granules in the mast cells of Ehrlich, widely distributed in connective tissue and especially along capillary and larger blood vessel walls, were shown to be the immediate source of heparin. As a result these cells,[5] represented by basophiles in the blood stream itself, are now being referred to as *heparinocytes*. The proximity of these "heparinocytes" to blood vessel walls is probably of some clinical significance in that the incidence of vascular thrombosis might be much higher were it not for this ready source of a physiologic anticoagulant.

Since the first reports by Murray[32] and Crafoord[33] on the efficiency of heparin in preventing thrombosis and embolism, and the concomitant improvement of inflammatory symptoms and signs of thrombophlebitis in four to five days, there has been considerable progress in the application of this drug.

Purpose of anticoagulant therapy is to prevent intravascular blood clotting. Absolute incoagulability of the blood *in vitro* is not necessary. A coagulation time of blood of between 15 and 40 minutes by the Lee-White method is adequate. Much higher coagulation time without deleterious effects has been the experience of most clinicians using heparin. We have had one patient whose blood failed to clot *in vitro* for 24 hours without any ill effects.

Heparin inhibits the action of thromboplastin, prothrombin, and of thrombin when combined with a serum-albumin component. Even more important is the antiplatelet agglutinin effect of heparin. Recent experimental evidence[34] also indicates that heparin hastens the resolution of early clots, promotes the growth of collateral circulation and accelerates the recanalization[35] of occluded vessels.

Originally heparin was administered by cumbersome continuous intravenous drip in saline or glucose for days and weeks. This was shortly supplanted by the less inconvenient and equally effective intermittent intravenous injections every four to six hours depending on the indications.

In 1944 Loewe and his associates[33] introduced the clinically effective use of crystalline heparin in a Pitkin menstruum composed of gelatin, dextrose and glacial acetic acid to delay absorption. The mixture is available in ampules containing 200 and 300 milligrams of heparin sodium salt with or without 12.5 milligrams of ephedrine sulfate and 0.5 milligrams of epinephrine hydrochloride as vasoconstrictor. The ampules also contain chlorobutanol as a preservative and eucupin to minimize the severe pain associated with these injections. Heparin in Pitkin menstruum is injected subcutaneously in the upper lateral aspects of the thighs and the effect, becoming apparent after 1½ hours, lasts from 41 to 61 hours with a maximum effect at 16 to 19 hours after administration; so that adequate anticoagulant therapy may be maintained[37] with one injection every second day.

In 1936 Crafoord showed that heparin has less effect during the first day postoperatively than when the same dose was given preoperatively. This increased resistance to heparin coincides with the known greater coagulability of the blood postoperatively as has been con-

firmed by De Takats [23] with the use of his heparin tolerance test.

Heparin may be given to any patient with an intact vascular system. How soon after operation it is given depends on the degree of hemostasis obtained during the surgery. The drug does not interfere with wound healing beyond the delay one normally notes as a result of hematomas from poor hemostasis. Menstruating and postpartum patients [38] have been adequately heparinized with no apparent complications. The one possible complication from heparin is bleeding, which is readily controlled by immediate transfusion of blood. Heparin can be almost immediately inactivated by the intravenous injection of 5 to 10 cubic centimeters of 1 per cent protamine sulfate solution.

In continuous intravenous drips heparin is initiated with 250 to 300 milligrams (25 to 30 cubic centimeters in a litre of fluid) at the rate of 20 to 30 drops per minute and more heparin is added after four hours if coagulation time is below 15 minutes.

In intermittent intravenous injections 50 to 75 milligrams of heparin are given every four to six hours through needles especially devised [5] to permit their being left *in situ* so that the injections may be administered by nurses.

Subcutaneously, in Pitkin menstruum, the initial dose of heparin is generally 400 milligrams for patients over 150 pounds in weight, and 300 milligrams for patients under 150 pounds using no more than 2 cubic centimeters with the vasoconstrictor at any one time.

It is essential to remember the marked individual variation in tolerance to the drug. Subsequent doses can be determined only by frequent observations of the coagulation time —at least daily after the first day.

DICUMAROL

In 1924 two veterinarians, Schofield and Roderick independently reported their observations on a strange bleeding malady affecting cattle. They attributed the cause to the ingestion of spoiled sweet clover hay. In 1931 Roderick demonstrated that the impaired coagulation of the blood was due to a reduction of prothrombin activity. Then followed eight years of intensive chemical research by Link and his associates [39] culminating in the extraction of the causative agent, its chemical analysis as 3, 3-methylenebis (4-hydroxycoumarin) and finally its inexpensive synthesis in the pure state officially known as dicumarol. Shortly following this work, in 1941, two groups, headed by Meyer,[40] and Allen,[41] began clinical studies on dicumarol as a means of retarding or preventing intravascular thrombosis.

Dicumarol is related to coumarin, which is used to scent inferior tobacco and is also an ingredient of artificial vanilla and of some perfumes. It is readily synthesized from salicylic acid. (Incidentally, salicylates have some anticoagulant effect, too). Little is known of the physiologic and pathologic activity of dicumarol beyond the fact that it suspends the formation of prothrombin by the liver without any demonstrable macroscopic or microscopic changes excepting in large toxic doses. Its delayed reaction time and its even longer duration of activity argues against its acting as an anti-prothrombin directly. Dicumarol acts only *in vivo*.

The sine-qua-non of dicumarol therapy is a reliable laboratory and a technician especially trained in prothrombin time determinations. This requirement cannot be overemphasized if serious complications are to be avoided and if a very valuable drug is not to be discredited because of faulty management. Intravascular clotting rarely occurs with prothrombin times lower than 30 per cent of normal and bleeding rarely occurs with prothrombin times higher than 10 per cent of normal. Thus between 10 and 30 per cent normal is the therapeutic range of dicumarol. That thrombosis does not occur with prothrombin times higher than 30 per cent is the experience of many, but levels higher than 30 per cent of normal are not reliable for anti-thrombotic effects. How fast this therapeutic range of dicumarol is achieved will vary to some extent on the initial dose and to a greater extent on the marked individual reaction or resistance to the drug. Patients have been kept in this therapeutic range for as long as three months [42] without harmful effects.

In adequate doses, dicumarol requires anywhere from 24 to 72 hours to exert its effects. Following its withdrawal the prothrombin time returns to normal in from two to ten days. Thus dicumarol is a potent drug with effects that tend to be cumulative and prolonged. Before instituting dicumarol therapy, the clinician must first ascertain the prothrombin time because of the numerous instances of nutritional or pathologic hypoprothrombinemia and the

rare cases [43] of congenital or familial hypoprothrombinemia.

Dicumarol further differs from heparin in that it exerts a definite angiotoxic effect [44] with peripheral vascular dilatation and actual rupture of some vessels [45] when given in large doses. These vascular accidents may be the cause of the central necrosis found in the livers of animals following toxic doses.[46] Interestingly enough, hemorrhage does not accompany drastic reductions in the prothrombin levels resulting from a single large dose of dicumarol. This suggests that the onset of the bleeding tendency involves more than a single suspension of normal prothrombin activity—a fact which some clinicians are now using to advantage in administering infrequent large doses of dicumarol without much concern about the resultant prothrombin level. Such practices, however, are to be discouraged pending further investigations. This observation may in some way be linked with the fact that all available circulating prothrombin appears to be used up normally in twenty-four hours.[43]

At the Mayo Clinic the incidence of minor bleeding (e. g. epistaxis, hematuria, petechiae and ecchymoses) was 3.1 per cent and 1.9 per cent for major bleeding which was generally confined to the operative wounds. There were two deaths in their series of 1686 cases. Occasional isolated deaths from dicumarol poisoning have been reported,[47] and there must be many more which have either been overlooked or have not appeared in the literature. In some instances,[5] patients under dicumarol therapy have been subjected to surgery without untoward effects but such practices are to be discouraged because of the danger of uncontrollable hemorrhage.

On the basis of experimental evidence, Quick [48] has advised that dicumarol is contraindicated in pregnant women because of the danger of abortion or miscarriage as well as the possibility of hypoprothrombinemia in the newborn. Clinically, however, dicumarol has been used antepartum [48] as well as post-partum [38] without any untoward effects.

SALICYLATES AND XANTHINES

Dicumarol may be synthesized directly from salicylic acid which exerts an anticoagulant effect itself *in vivo* one-twentieth as strong as dicumarol. Acetyl salicylic acid is even more potent than salicylic acid [49] in this respect. Thus some caution must be exercised in the prolonged and large dose salicylate medication common in the rheumatic states.

The methylated xanthine drugs (caffeine, theobromine and theophylline) have a marked hyperprothrombinemic action [39] which counteracts, to some extent, the effect of dicumarol. The common and prolonged use of these drugs in cardiacs, (a group three times more susceptible to thrombosis than non-cardiacs) strongly suggests the contributory role of these drugs in the increased tendency of these patients to thrombosis.

ADMINISTRATION OF DICUMAROL

Dicumarol is an inexpensive drug supplied in 50 and 100 milligram oral tablets. Solutions for parenteral use are unstable and not practical for clinical use. As a working guide for dicumarol therapy the following schedule is recommended:

1st day (A) Prothrombin time determination.
(B) 200 to 300 mg. of dicumarol in a single dose depending on the prothrombin time, size and clinical condition of the patient.
2d day (C) Prothrombin time determination.
(D) 100 to 200 mg. of dicumarol depending on apparent response to first dose of the drug.
3d day (E) Prothrombin time determination.
(F) 50 to 100 mg. of dicumarol if prothrombin time is greater than 20 per cent normal and none if lower. If prothrombin time is below 10 per cent normal transfuse immediately with fresh blood and give 60 to 70 mg. of menadione bisulfite intravenously.

On subsequent days, the schedule is same as on the third day.

The use of fresh blood is emphasized because stored blood loses its prothrombin activity rapidly.

Ordinarily smaller doses of dicumarol will be needed following biliary tract or upper abdominal surgery in which there has been any handling of the liver because of the postoperatative drop in normal prothrombin following any trauma to the liver.[50] This drop may amount to as much as 25 per cent.

As with heparin, dicumarol should be continued for about ten days to two weeks or at least until the patient is ambulatory.

COMBINED MEDICATION

The qualities of the two drugs [51] make their combined use the treatment of choice [52] for thrombo-embolism. The patient is placed on the quick-acting heparin and the slow-acting dicumarol simultaneously with the intention of eliminating the heparin after the first two days, by which time the dicumarol effect will have become manifest. If for any reason heparin is to be continued while the patient is receiving dicumarol, far less than the usual amount of heparin will be needed to obtain the necessary prolonged coagulation time because of the hypoprothrombinemia from the dicumarol.

CONTRAINDICATIONS TO ANTICOAGULANT THERAPY

Heparin and Dicumarol:

1. Absence of adequate laboratory and transfusion facilities.
2. Purpura.
3. Blood dyscrasias with bleeding tendency.
4. Severe hypertension.
5. Intracranial or intraspinal surgery.

Dicumarol:

1. Existing prothrombin deficiency e.g. jaundice, hepatic disease and malnutrition.
2. Renal insufficiency.
3. Subacute bacterial endocarditis.
4. Ulcerative lesions or open wounds.
5. Necessity for surgical operation within one week.
6. Pregnancy.

Precautionary points:

1. Daily blood coagulation with heparin.
2. Daily prothrombin time with dicumarol.
3. Daily examinations of patients for evidence of masked or internal bleeding.
4. Avoid concomitant use of salicylates and dicumarol.

The table below compares the relative merits and qualities of heparin and dicumarol as anticoagulants:

Heparin		Dicumarol
Animal	*Origin*	Synthetic
Parenteral	*Administration*	Oral
200-300	*Daily Dosage (Milligrams)*	50-100; (initial to 300)
None	*Toxicity*	None in therapeutic dosage
Blood Coag.	*Essential*	Prothrombin time
Time 15 to 40 minutes	*Laboratory Test*	10-to-30% Normal
$9.00	*Average daily cost including lab.*	$5.00

ANTICOAGULANTS VS. LIGATION

Some clinics have elected to treat the thrombo-embolism by one method to the exclusion (and in some cases with biased criticism) of other procedures. Thus we have had "femoral vein ligation" and "anticoagulant" schools of therapy. It is best to be familiar with the merits and limitations of all available procedures, using each as the indications arise. No one will question the wisdom of ligation of a septic thrombophlebitis; there is no more positive method of preventing a fatal embolus than to block the path of a *known* intravascular thrombus. But we cannot always suspect a thrombus which may be dormant while its friable tail, growing ominously downstream, threatens to break off at any instant and possibly block off a vital arterial trunk.

How about the more radical vena cava ligations? Here, there is considerable question in spite of their absolute necessity in a few isolated instances. Widespread use of such major surgery (unless as a heroic measure in desperate cases) can lead only to more harm than good. The judicious and early use of anticoagulants will in most cases make such drastic circulatory insults entirely unnecessary.

A few years ago, I treated a patient with apparent thrombophlebitis involving both iliac veins following a spontaneous abortion and with two definite pulmonary emboli. The patient was heparinized for two weeks and made an uneventful recovery. Today, our first thought in such a case would be vena cava ligation.

Some form of active treatment must be instituted early on the suspicion or finding of a thrombus or embolus. The old *laissez faire* attitude of watchful waiting is obsolete and dangerous.

Anticoagulants with chemotherapy are recommended in all cases suspected of pyelophlebitis with high ligation of the appendiceal or ileo-colic veins. Excellent results without ligation of the jugular vein have been achieved with anticoagulants and chemotherapy in grave cases of cavernous sinus thrombosis. I have seen only two such cases in the past few years and both recovered with anticoagulants, chemotherapy and antibiotics.

For the universal prophylactic adoption of any form of therapy for thrombo-embolism it

must be sufficiently inexpensive, easily executed, readily available and free of any deleterious effects. Unfortunately neither ligations nor any of our present anticoagulants can satisfy all these criteria.

We must guard against any false sense of security with any treatment or combination of treatments now being employed in combating thrombo-embolism. Fatal accidents have and will continue to recur following what was considered adequate vein ligation and during adequate anticoagulant therapy. There will be thrombo-embolic accidents as long as there remains the complex and incompletely understood medium of blood flowing through our veins. We can only hope to reduce the incidence of these accidents and in that respect the profession can point with pride to the progress made in the past decade.

SUMMARY

1. Thrombo-embolism is of interest to any clinician having under his care patients of middle or advanced years, requiring surgery or confinement to bed for more than a few days at a time.

2. Anticoagulants, early active movements and early ambulation (with vein ligations when indicated) are the treatments of choice in thrombo-embolic disease.

3. Dicumarol is a highly potent cumulative drug with prolonged effects, the use of which should be restricted to patients under close observation with at least daily prothrombin levels.

4. The replacement of Gatch beds by the Saunders oscillating bed in the immediate postoperative period is recommended whenever practical.

5. Early recognition of thrombo-embolic complications is necessary for proper and adequate therapy.

6. Some form of active therapy should be instituted immediately upon the suspicion (or discovery) of a thrombus or embolus.

7. With the judicious use of these prophylactic and therapeutic measures, the incidence of thrombo-embolism can be reduced to an insignificant minimum. Prompt action may save many lives and spare many more patients the discomforts and invalidism of postphlebitic sequelae.

8. There exists at present no one safe, fool-proof, easy or inexpensive method of either avoiding or treating thrombo-embolism.

The footnotes and references appear in the author's reprints.

15 Salem Street

ELECTRICALLY DRIVEN TUNING FORK

An electrically driven tuning fork is now being used as a guide to vitamin B treatment of peripheral neuritis in diabetes, Drs. William S. Collens, Louis C. Boas and James D. Zilinsky report.

The tuning fork helps locate impairment of ability to detect vibrations the earliest function to be disturbed in peripheral neuritis.

Impairment of this vibratory sense occurs almost as often and almost as severely in diabetics without symptoms of neuritis as in those who have such symptoms. The tuning fork therefore will help to detect this trouble before it has progressed very far.

Treatment with vitamin B complex relieved the symptoms and brought improvement in vibratory sense as detected by the tuning fork in more than half the patients.

MEDICAL SCHOOL STUDY PLAN ACCEPTED

Last April The Medical Society of New Jersey suggested that the Governor appoint a representative committee consisting of four physicians designated by the Medical Society, four citizens named by Rutgers University and eight persons appointed by the Governor.

Word has just come from the State House that Governor Driscoll has accepted the proposal and that the personnel of the study committee is now in the process of selection. The Governor's announcement was issued "with the specific understanding that the committee will include in its report detailed analysis of the financial requirements for the support of any project proposed and recommendations for adequate methods of meeting such requirements."

INFECTIOUS HEPATITIS AND LIVER FUNCTION*

MAX MAGNES, M.D., Paterson, N. J.

During the winter of 1941-1942, I was stationed at Fort Hamilton and noticed a large number of cases of jaundice. Although this did not amount to an epidemic, the cases seemed to be persistent and constant. I collected sixty of them and made a statistical analysis. Two factors stood out: every one of these jaundiced patients had received yellow fever vaccine; and the jaundice appeared two to four months after administration of the vaccine. At that time, I wrote a paper embodying these observations and offering certain conclusions, but failed to obtain official authorization for its publication. However, a few months later, the War Department released a statement that the large number of jaundice cases then prevalent in the army were due to contamination of the yellow fever vaccine. Certain lots, it was stated, had become contaminated by a virus. After this was corrected, only an occasional case of jaundice appeared in the states.

Although the ease with which epidemics spread in the army may account for the many cases of infectious hepatitis, this alone did not explain the high incidence in the European Theatre of Operations. Other factors played a role in predisposing men to hepatitis. In combat areas, malnutrition and fatigue made these soldiers good candidates for liver infections. Although I have never seen this in the medical literature, a high proportion of patients with infectious hepatitis had had an upper respiratory infection before the onset of jaundice. Diminution of the glycogen content of the liver due to a poorly balanced diet makes the liver more susceptible to injury. This also applies to low protein diets since protein has been found to be important in liver therapy. The deficiency of certain components of vitamin B may also play a role in liver damage.

The cause of infectious hepatitis is now definitely known to be a filterable virus.[1] The virus is present in the stools and blood of the infected patient, and the washings through a filter can transmit it to human beings. There are probably different strains of this virus since in homologous serum jaundice, the strain is not infectious when given orally nor does it appear in the stools as do the other strains of infectious hepatitis. In infectious hepatitis the virus is present in the stools and blood in the early stages of the disease. There are also cases of hepatitis that are transmitted by transfusion of blood from donors who are in the prodromal stages of the disease. Capps[2] reports an epidemic of infectious hepatitis in a detachment of 110 men who received tetanus toxoid by the "multiple dose per syringe" technic. Of these, at least 20 per cent developed the disease 21 to 38 days later.

The incubation period varies in different strains. Acute infections may have an incubation period of 15 to 45 days while hepatitis due to homologous serum jaundice may develop the disease two to four months later. One type of hepatitis that produces serious consequences (and one that is often overlooked) is that form of jaundice caused by *leptospira icterohemorrhagica* known as Weil's disease. Many medical officers just assumed that all cases of hepatitis were of the virus type. Only when an Army Department Bulletin emphasized the importance of looking for the *leptospira* in these cases, (particularly in overseas areas) was a persistent search made for this spirochete. In Erance, within a short period of time, three cases were recognized among patients in our general hospital. The *leptospira* was found by careful dark-field examination of the urine. Recently a report[3] from the Detroit area of 78 cases occurring in the last ten years, emphasizes the importance of this disease in this country. In this review[3] the authors stress the value of doing lepto-spiral agglutination tests for accurate diagnosis. In numerous other types of hepatitis, the liver damage is an inconstant but not infrequent finding.

* Read before the Annual Meeting of The Medical Society of New Jersey, April 27, 1948.

1. Havens, Jr., Paul W.; Bulletin of the New York Academy of Medicine, 24:195, (March 1948).
2. Capps, R. B., Sborov, V., and Schiffley, P. S.: Journal of the American Medical Association, 136:819, (March 20, 1948).
3. Molner, J. G., Meyer, K. F., and Raskin, H. A,: Journal of the American Medical Association, 136:814, (March 20, 1948).

Shortly after World War I, there was a change in the concept of the pathology of infectious hepatitis or "acute catarrhal jaundice" as it was then known. Although occasional cases may be caused by inflammation or catarrh of the bile ducts, most cases are due to damage to the liver cells, the hepatalcellular jaundice or hepatitis. No opportunity for proving the latter had presented itself previously since few fatalities had occurred prior to World War II. However during the last war, autopsies performed on men killed in battle while jaundiced showed definite liver damage instead of the catarrhal involvement of the bile ducts.

Physiologically, blood from the portal vein is filtered by the liver cells. Naturally any toxins from the portal blood stream will affect the parenchyma of the liver. This not only applies to ingested poisons but to infectious diseases which may cause an acute necrosis of the liver cells. In cases of infectious hepatitis seen in the last war, studies made by Mallory [4] show inflammatory and degenerative changes in the liver. The inflammatory changes are the same in all forms of the disease, but the degenerative changes differ in the fatal and non-fatal cases. In the inflammatory reactions there is a marked mononuclear cell infiltration of the peri-portal area with a mild infiltration of the intra-lobular area. This infiltration consists of macrophages, lymphocytes, and a few eosinophiles and polymorphonuclear leukocytes. The degenerative changes in the liver cells in the fatal cases of hepatitis show a widespread necrosis with lysis of the cells. This process extends outward from the central vein to the periphery so that the whole or almost entire lobule is involved. If this process is very rapid, all of the liver cells will have disappeared before there is evidence of jaundice. In non-fatal cases, the individual liver cells show changes varying from a cloudy swelling to a definite necrosis. The bile capillaries may be blocked or destroyed. In the less fulminating cases (where the patient lives longer than ten days but eventually expires) the process was not so rapid as in the fatal fulminating cases. There the degeneration took place at the periphery of the lobule and produced microscopic nodules giving a picture of multiple nodular hyperplasia. Various stages of the disease were studied by peritoneoscopic biopsies (Mallory [4]) during an epidemic. Three to five days before onset of jaundice, active inflammatory and degenerative changes were already present and even regeneration was taking place since mitotic figures were seen microscopically. In some cases there were no signs of clinical jaundice, but in the serum bilirubin was elevated. The most surprising finding was in cases where there was neither clinical jaundice nor elevated serum bilirubin and yet definite histological changes in the liver cells had occurred. Robolm and Iverson in similar studies (by aspiration biopsies in 1939) found the maximum histologic changes one week after onset of jaundice which usually subsided one month later. Changes in the liver one month later showed only a mild or moderate amount of connective tissue. In some ways these findings correspond to those of Mallory. The latter also found histologic evidence of activity weeks and months after the jaundice had subsided in cases where symptoms were still present or where liver function tests were still abnormal. One such case showed a persistent activity 2½ years after the initial attack.

Infectious hepatitis is one disease in which the laboratory tests are as important as the clinical findings; and for following the course of the disease, the tests are even more important. This is especially true since many liver diseases develop gradually without presenting any definite clinical picture. Without jaundice, enlarged liver, or ascites the vague complaints may not be enough to make the physician suspicious of the liver; and even in the presence of ascites, jaundice, or hemorrhage, liver function tests are of invaluable aid in detecting whether liver damage is the cause of these symptoms. Even apart from the differential diagnosis, the tests are of the utmost value in following the course of the disease and in the prognosis. The selection of the test is a matter of personal like and dislike. Preferences among these tests vary with different clinicians.[5] Of the great number of tests, only a few are commonly recommended, and even those few are occasionally discounted by some internists. For example, in a recent surgical journal, a writer states that none of the dye tests are of any value in testing the function of the liver, except one that visualizes the gall bladder. He concludes that tests of excretory function of the liver are of no value. Most of us who are acquainted with these tests realize that the bromsulfalein test is one of the best tests of liver functions.

The primary principle in understanding those tests is knowlege of the large number of functions the liver has. Second, we must understand that the liver has a large reserve capacity; and finally it has a marked capacity for regeneration. That is why liver functions

4. Mallory, Tracy B.: Bulletin of the New York Academy of Medicine, 24:197, (March 1948).

5. Tumen, H. J.: In Gastro-Enterology (Bockus). Philadelphia, W. B. Saunders Co., 3:66, (1946).

may be normal in spite of extensive damage to the organ. It is just as foolhardy to believe that one test will measure the condition of the liver as it would be to suppose that one psychology question will test the mental capacity of the brain.

According to Tumen's classification,[5] liver function tests are based on seven important functions of the liver. These are: (1) metabolism of bilirubin and its products, (2) the ability of the liver to excrete foreign substances such as dyes, (3) the activity of the liver in carbohydrate metabolism, (4) the activity of the liver in protein metabolism, (5) the action of liver in lipoid metabolism, (6) the detoxifying function of the liver, and (7) the function of water metabolism. In the past, there have been developed from 75 to 100 different liver function tests. Many have been discarded. For that reason, I advise caution. However since a small number of tests have been proved to be of great value, a good picture of the patient's liver condition may be obtained by doing several of these.

The Vandenburgh, icteric index and urobilinogen determinations are tests of recognized value. The Vandenburgh test is particularly valuable in following the course of the jaundice, and is preferred to the icteric index by some because it is said to be more accurate. The urobilinogen test can be done both on the urine and stool. Normally from 30 to 200 milligrams of urobilinogen are excreted in the feces in 24 hours and one to three milligrams in the urine. In hemolytic processes and in pernicious anemia there is a marked increase of urobilinogen in the feces whereas in hepatitis there is an increase of urobilinogen in the urine. In complete obstruction of the common bile duct, there is a complete absence of urobilinogen in the feces. Overseas, where extensive liver function tests could not be done, urobilinogen tests on the urine were of great value in following the progress of the patient and determining the amount of liver damage by quantitative analysis. As a dye excretion measure, the bromsulfalein test has been found to be of the most value [6] despite differences in opinion. There are also modifications and variations depending on the amount of dye injected per kilogram of body weight, and also on the time the serum is extracted for comparison with the color standards. This test is not used while the patient has jaundice. Of all the procedures which measure the carbohydrate function of the liver, the galactose tolerance test is the one most used by Bockus [5] and his associates. There are several reasons for his preference, the main one being that galactose is primarily used by the liver. It is of particular value in acute liver conditions, and must be done early in the disease to be of any value. A measure of the detoxifying power of the liver is the hippuric acid test [8] which has become a valuable liver function test recently. This is based on the ability of the liver to produce glycine for the synthesis of hippuric acid. The test can be done either orally or intravenously. The protein content of the serum is determined in a test based on the protein metabolism of the liver. There is a decrease in the albumin in hepatitis since it is not manufactured by the liver. If continued long enough, the osmotic pressure is reduced causing edema and ascites. One of the tests involved in the function of lipoid metabolism is that of cholesterol and cholesterol esters. This partition of fats in the plasma is decreased in hepatitis, and if the esters are absent, prognosis is usually poor. There are other procedures which are becoming more common and more popular, but which duplicate functions which the above mentioned tests measure. These are thymol turbidity, cephalin flocculation and alkaline phosphatase. Wade [7] and Richman have found the last test to be positive in 98 per cent of patients with liver damage.

To recapitulate, liver function tests are of value (1) in the differential diagnosis of jaundice, (2) in the determination and extent of liver damage, (3) in the progress and prognosis of the disease. The most important part of the therapy is rest. A high caloric diet with emphasis on carbohydrates and protein, and the prevention of intercurrent infections are of additional value in the patient's recovery.

6. Svirbeley, A., Monaco, B., and Geford, C.: Journal of Laboratory and Clinical Medicine, 31:1133, (July 1946).
7. Wade, L. J.: American Journal of Clinical Pathology, 16:426, (July 1946).
8. Mateer, J. G., et al.: Journal of the American Medical Association, 121:723, (Sept. 13, 1942).

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HYSTERECTOMY *

PATHOLOGIC ANALYSIS OF 2000 UTERI REMOVED AT OPERATION

SALVATORE J. ROSE, M.D., Orange, N. J.

In compiling the statistical data for this paper, it became evident that there is considerable confusion with reference to terminology on the part of both gynecologists and pathologists. Perhaps the most common diagnosis applied to uteri in the laboratory is "chronic metritis". It has long been the policy of some pathologists, for obvious reasons, never to render a diagnosis of "normal uterus". Bearing in mind certain criteria of average normal measurements, any uterus which deviates from that normal could presumably be labelled by a pathologic term. If the uterus be small, "atrophy" or "hypoinvolution" is applied. It is in enlarged uteri where considerable thought is necessary in order to apply the diagnosis which best fits the pathologic changes.

It was noted in the survey that the most common symptoms which lead to hysterectomy were:

(1) Fibroids (uterine enlargement)
(2) Bleeding
(3) Pain

SIZE

Most authorities state that the dimensions of a normal virgin uterus are 5.5 x 3.5 x 2.5 centimeters. Any deviation from these figures would, of necessity, constitute a pathologic condition. From the histologic standpoint, there are definite concepts with reference to the relative proportions of muscle and connective tissue. When this connective tissue proportion is exceeded, pathology exists. A number of possibilities must be considered when pelvic examination reveals an enlarged uterus and especially when such enlargement is accompanied by bleeding. The correct classification of pathologic entities is as follows:

(1) Pregnancy
(2) Involution
    (a) Normal involution
    (b) Subinvolution
(3) Myometrial hypertrophy
(4) Chronic metritis
    (a) Myometritis
    (b) Fibrosis uteri
    (c) Endometritis
        (1a) Acute endometritis
        (2a) Chronic endometritis
        (3a) Syncytial endometritis
(5) Endometriosis (adenomyosis)
(6) Fibromyomata
(7) Carcinomata
    (a) Fundal
    (b) Cervical
(8) Sarcomata

PREGNANCY

The removal of a gravid uterus is occasionally encountered in every hospital in spite of great care and the use of the Aschheim-Zondek test. One should not, however, encounter too much difficulty in detecting a gravid uterus when the abdomen is opened because of the increased size, soft consistence, and great vascularity of the serosa.

INVOLUTION

Following delivery and within a period of about two months, the uterus shrinks from its gravid weight to approximately two ounces followed by expulsion of the old decidua and the regeneration of a new endometrium. The chief changes occur in the blood vessels. There seems to be an increase in the amount of elastic tissue as well as a process of canalization within the lumina of the old blood channels giving the organ a greater vascularity. This constitutes normal involution.

When the process is incomplete, we deal with "subinvolution" characterized by an increase in the amount of elastic tissue, increased fibrosis, edema and congestion. The displacements which commonly follow childbirth or infection inhibit normal involution and are responsible for these changes. Because of the increased amount of elastic tissue about the blood vessels and between the muscle bundles, this is frequently confused with chronic metritis.

* Read by invitation to the Annual Meeting, The Medical Society of New Jersey, April 27, 1948.

MYOMETRIAL HYPERTROPHY

Hypertrophy of the uterus is rarely encountered in the laboratory. It occurs in women who have not borne children and in whom there has been no evidence of previous infection. Microscopically the structure of the myometrium is normal except for the great increase in the number of muscle cells resulting in increased thickness.

MYOMETRITIS

The term "myometritis", of necessity, implies an inflammatory condition. Such inflammation is evident only in the acute variety and presents all the earmarks of inflammation with vascular congestion and the presence of an exudate. Most cases are due to puerperal or post-abortion infection. The gonococcus and the streptococcus are most frequently encountered. In common hospital practice, acute myometritis is relatively rare.

CHRONIC METRITIS

Chronic metritis is a long neglected entity, though in recent years, it has become the subject of much study. Schwarz encountered the lesion frequently, often associated with chronic endometritis. The causes are the same as those of acute myometritis and the condition is frequently associated with subinvolution. Microscopic evidences of the chronic inflammation are found in the fibrous tissue and in the round cells and plasma cell infiltration. This resultant fibrosis is undoubtedly responsible for the menorrhagia and was termed many years ago "insufficientia uteri" by Theilhaber.

FIBROSIS UTERI

As the term implies, this is characterized by an enlarged uterus with an increased connective tissue component, rendering the organ firmer than usual. It represents an end stage resulting from many pathologic causes.

ENDOMETRITIS

Endometritis may be acute, sub-acute or chronic. The acute form is rarely encountered in the laboratory and when it is, occurs either in the child, in the post-abortal or in the senile woman. We are all familiar with the effect of estrogenic hormone on the lining of the uterus as well as of the vagina. The single-columnar epithelium of infancy as well as the atrophic epithelium of the aged women are both less resistant to infection. When acute endometritis is encountered in the laboratory, it constitutes a curiosity. Chronic endometritis, except in its specific forms, e.g. tuberculosis, is extremely rare. This diagnosis was most common prior to the advent of hormonology and modern pathologists no longer render the diagnosis "chronic metritis" but prefer to use such terms as "hyperplastic endometrium, proliferative or secretory phase".

SYNCYTIAL ENDOMETRITIS (SYNCYTIOMA)

I have occasionally encountered either uterine currettings or a uterus in which the endometrium (as well as the uterine wall) showed

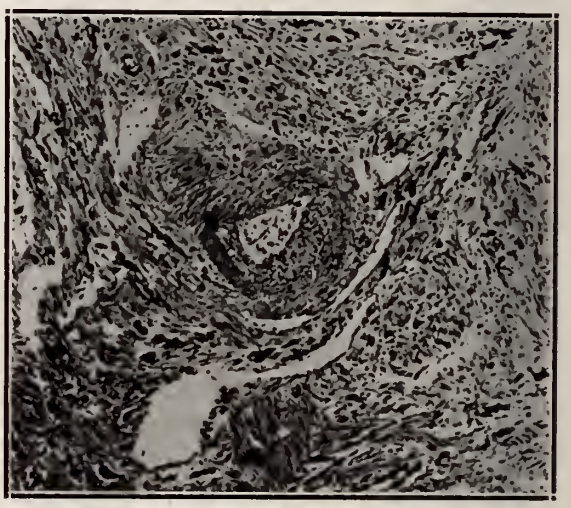


Figure 1. Syncitial endometritis.

evidences of inflammatory reaction and the presence of large bizarre cell masses resembling syncytial cells. The process, at first glance, might be considered a malignant chorioma (chorio-epithelioma). Careful study shows invasion of the myometrial wall by syncytial cells which frequently occurs with normal pregnancy. Their trophoblastic tendencies are still evident even after the uterus is emptied. This lesion was recognized by Marchand, who labelled it "atypical chorioma". Because of the accompanying inflammation, we refer to the process as *syncytial endometritis*. The lesion is essentially benign.

ENDOMETRIOSIS

A common cause of uterine bleeding is *endometriosis,* formerly known as *adenomyosis.* Aberrant endometrial tissue is subject to hormonal influences which will explain the diversified histologic appearances of endometriosis. The endometrial implant will show either a proliferative, secretory or pre-gestational phase depending upon the time when the uterus was removed.

FIBROSIS

The slightly enlarged uterus which is firm and associated with menorrhagia has for many years been the subject of much controversy. Such enlarged organs constitute the majority of uteri coming to the laboratories. The so-called "endometritis" which was often found in such uteri (and offered as an explanation for the menorrhagia) has now been shown to be a misconception. Great confusion in terminology has arisen with such terms as chronic metritis, chronic subinvolution, myometrial hypertrophy and arteriosclerotic uterus being used interchangeably. This is understandable when one considers that a diversity of changes may occur in the same uterine wall with the result that the pathologist applies the term which best fits the predominant pathology histologically. The term fibrosis indicates that connective tissue reaction is present, but it may not be possible to postulate what the disease entity was that brought it about.

Scanzoni, Bell, Goodall and others described these changes and considered them due to chronic metritis,—the result of inflammation of one sort or another. Others do not accept the inflammatory theory. Findlay regarded the changes as due to prolonged chronic passive congestion. Novak takes the view that both chronic metritis and chronic subinvolution play a part. Williams found no fibrosis but did find hypertrophy of the myometrium and proposed the term "myometrial hypertrophy." Hence it becomes necessary to distinguish one entity from the other and to establish certain definite criteria for the recognition of each.

In the normal myometrium the smooth muscle fibers collect into various-sized bundles interlacing in all directions. Surrounding each individual muscle fiber there is a thin connective tissue sheath and separating the muscles into bundles are varying amounts of connective tissue. This connective tissue is composed of elastic fibers, collagen and reticulum fibers. In true *fibrosis uteri* an abnormal amount of connective tissue occurs between the muscle bundles, particularly around the individual muscle fibers. Mallory's or Masson's trichrome stain will readily detect this increased amount of connective tissue in fibrosis uteri as compared with normal controls. The results are not always conclusive when attempts are made to compare the relative amounts of connective tissue. There is most always a significant difference in the submucous layer of the myometrium, the fibrous tissue making up 15 per cent or more of the thickness of this layer in fibrosis uteri. This would distinguish fibrosis uteri from simple muscular hypertrophy and subinvolution and establishes a defect of the myometrium as a causative factor of menorrhagia.

FIBROMYOSIS

A rare uterine growth resembling adenomyoma (endometriosis) is that known by a variety of names. It differs from true endometriosis in that the growth does *not* contain glands. Goodall termed the growth "stromatous endometriosis", but this is a misnomer since no glands are in the lesion. Frank coined the term "fibromyosis uteri" but this is inadequate since it does not denote the actual endometrial character of the connective tissue process.

Castler (1920) described the first case as one of *adenomyosis,* without glands. By 1941 Goodall reported eight cases. Robertson in 1942 described seven cases of what he termed "benign stromal endometriosis". This author considered "adenomyosis" and "stromal endometriosis" as variants of the same process, except that the latter may continue to grow after cessation of the hormonal activity of the menopause. More recently, Henderson (1946) reported seven cases of this entity and named the process "endolymphatic stromal myosis".

The clinical features are menorrhagia, and abdominal mass and pain. Grossly, there is a resemblance to ordinary fibroid with tendency to undergo degenerative changes. The micro-

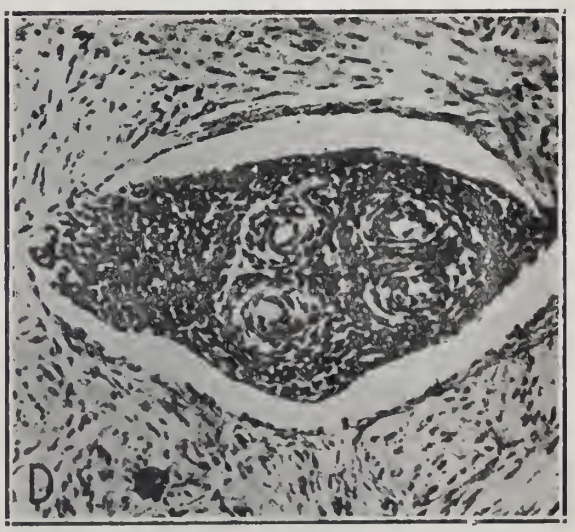


Figure 2. Fibromyosis uteri.

scopic appearance is that of broad masses of cells infiltrating between the bundles of smooth muscle. Often these cells grow into (and along) dilated lymph channels like endotheliomatous process. There are cell masses composed of fairly uniform size with oval and vesicular nuclei with occasional mitrotic activity even though benign. The cytoplasm is scanty. Abundant reticulum can be demonstrated with reticulum stains.

Thus the growth exhibits both endometrial and vascular components. Undoubtedly, some of the vascular channels are myometrial arteries which come to be surrounded by growing stromal cells. At times the vessels are formed by the stromal cells themselves. Smooth muscle cells cannot be demonstrated. Both blood and lymph vessels are formed in the growth. The stromal cells may arrange themselves about vessels in peritheliomatous fashion. True endometriosis has two components: stroma and glands. While we are wont to consider the glandular component as the important one, we cannot belittle the stroma. Novak regards this stroma as an accompanying part of the endometrium which has attained a high degree of differentiation and in this respect differs from the stroma of other organs. At times the glandular epithelium may become flattened and compressed as to resemble endothelium.

Hill believes that these stromal cell growths arise from mesenchymal cell rests laid down during the development of the mullerian duct system and that they are sensitive to endocrine stimulation. Ordinarily, the growth is in the nature of a hamartoma with limited capacity for growth. When the hyperplasia is extreme, the process may become autonomous resulting in a low grade fibrosarcoma.

In the differential diagnosis one must consider endometrial sarcoma, leiomyosarcoma and anaplastic carcinoma of the endometrium. In fibromyosis uteri (endometrial type) there is not the pleomorphism, mitotic activity and invasiveness of these other malignancies. Fibromyosis may be confined to the uterus or may extend into the parametrial tissues. Generally, those confined to the uterus are cured by hysterectomy while those extending beyond the uterus may recur. There may be a long latent period of from ten to twenty years.

SARCOMA OF THE UTERUS

Sarcoma of the uterus is a rare tumor. Since Virchow's and Mayer's first description in 1860 numerous articles, namely case reports have appeared. Sarcoma has been found associated with adenocarcinoma and the lesion has been encountered during pregnancy. The frequency of sarcoma ranged from 0.4 to 10 per cent according to different authors. Best figure is perhaps 2 per cent of all uterine tumors and 5 per cent of those which are found to be malignant. This great difference in figures is due to differences in opinion. In some institutions, the ratio is high because the pathologist interprets certain cellular changes in a fibromyoma as malignant. It has been my experience that pregnancy brings about changes in a fibroid which are easy to mistake for myosarcoma. I have seen the same thing happen in a cervical polyp during the gravid state. the changes of which are undoubtedly hormonal. *I have never seen the diagnosis of sarcoma of the uterus made before operation,* though it should be more often suspected. This is especially so when the patient has been under gynecologic observation and the uterine mass has grown larger in a short period. Unfortunately, there is nothing in the clinical history nor the pelvic examination which can differentiate it from carcinoma of the uterine fundus. Wolfe maintains that the diagnosis can be made in 50 per cent of the cases by diagnostic dilatation and curettage.

There are many ways of classifying sarcomata, none of which are complete. The growths may be: (1) Primary—those not arising in a pre-existent fibromyoma or (2) Secondary—from pre-existent fibromyomata. Histologically, the tumors may be divided into: Spindle cell, round cell, giant cell, polymorphous cell, mixed cell, or Hodgkin's sarcoma depending upon the cell type of the tumor. This multiplicity of morphologic variation can be readily explained if one considers that new muscle cells in the myometrium are formed by the differentiation of certain small round cells of undifferentiated mesenchyma normally present. That this mesenchymal cell is multipotent is attested by the appearance of mixed tumors and osteogenic sarcoma. Since multinucleation of the tumor cells is an almost constant feature of uterine sarcoma it appears doubtful whether true giant cell sarcoma should be considered an entity. These cells may represent histiocytes.

In general, the greater the number of cells of the giant type, the lower the degree of malignancy. In fact, the process is relatively benign and rarely metastasizes. Spindle cell sarcoma is the more malignant as well as the more frequent. The secondary forms (those arising in a pre-existent fibromyoma) as less malignant than those arising primarily. Mitotic activity is also a rough index. The general histologic picture is the same whether the tumor arises from either. The term "sarcomatous degeneration" is frequently applied to these tumors by pathologists but I doubt that such

degeneration or metaplasia of the pre-existent uterine cells occurs. There is really no evidence that a well differentiated smooth muscle cell or a fibrous connective tissue cell ever becomes differentiated. The forerunner of uterine sarcoma is undoubtedly the undifferentiated mesenchymal cell normally found in the normal uterine wall as well as in the interstitium of the fibromyoma. Masson's trichrome stain is of great aid in the study of these tumors.

HODGKIN'S SARCOMA

In 1944, Jackson and Parker reported on a large series of 326 cases of all varieties of Hodgkin's disease. In 59 cases of Hodgkin's

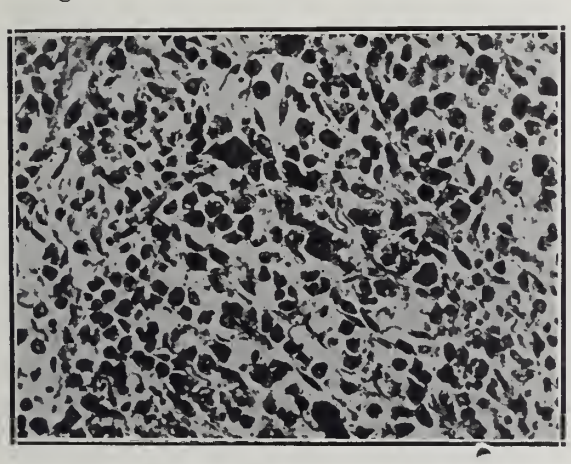


Figure 3. Sarcoma of uterus.

granuloma which came to autopsy the uterus was involved in two, and among 27 cases of Hodgkin's sarcoma there was one with uterine involvement: an incidence of 0.34 and 3.7 per cent respectively. Naumann in 1947 added six more cases. In all of the cases the involvement of the female sex organs represents only one localization of a widespread process. The oldest case on record is that of a woman in the ninth decade in Jackson and Parker's series.

ADENOCARCINOMA OF FUNDUS

This form of growth constitutes about 90 per cent of endometrial carcinomata and is sufficiently familiar to both surgeon and gynecologist to deserve no special mention in a meeting of this kind.

CHORIO-EPITHELIOMA OF UTERUS

It is necessary to differentiate this lesion from two others occurring as a result of pregnancy, namely chorioma and syncytitial endometritis.

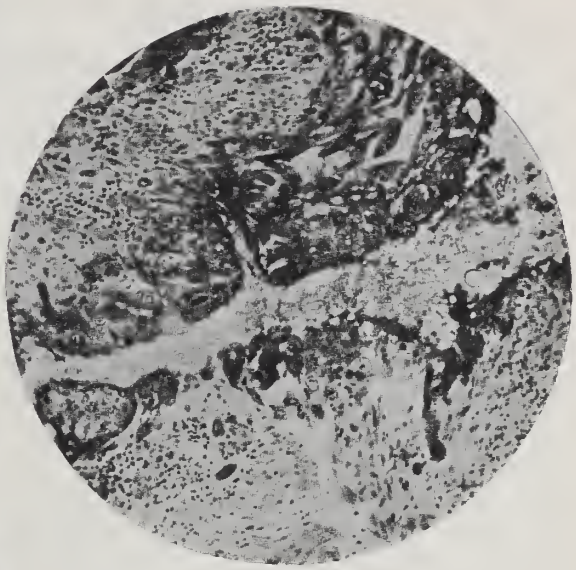


Figure 4. Chorio-epithelioma—high power.

Chorio-epithelioma is a relatively infrequent malignant tumor arising from the trophoblast and behaving much the same as normal pregnancy except for its tendency to exhibit unlimited invasive growth, to get into blood sinuses and lymphatics and to metastasize to various parts of the body. It should be readily differentiated from syncytial endometritis by the absence of inflammation and the earmarks of malignancy.

TUBERCULOSIS OF UTERUS

No cases of uterine tuberculosis were encountered in this series, though I have seen the lesion several times in general hospitals involving either the endometrium or the adnexa. Here is a slide of a tuberculous lesion of the fallopian tube which would call for panhysterectomy.

CARCINOMA OF CERVIX

Perhaps the most frequently encountered uterine malignancy is epidermoid carcinoma of the cervix (90 per cent), 10 per cent being either adenocarcinomata or mixed cancer (adeno-acanthoma). The epidermoid type resembles closely, squamous cell cancer seen in any of the covering epithelium of the body. All the cellular components of stratified squamous epithelium are represented in the growth with or without the tendency to keratinization and metaplasia. Such metaplasia may be observed in adeno-acanthoma which is really a mixture of squamous and glandular cancer. I have seen this lesion many times in the cervix and in the margin of the lip as well as in the anus, in fact at any muco-cutaneous junction.

SARCOMA BOTRYOIDES

Mixed tumors derived from two or three germ layers are rarely seen in the uterus. Shaw (1928) described grape-like tumors of the cervix containing striated muscle and cartilagenous elements resembling the sarcoma botryoides or rhabdomyoma encountered in the vagina in children. This tumor presents polypoid masses the size of small muscat grapes and often resembling nasal polyps. Microscopically, they resemble spindle-cell sarcoma exhibiting myomatous degeneration and great vascularity.

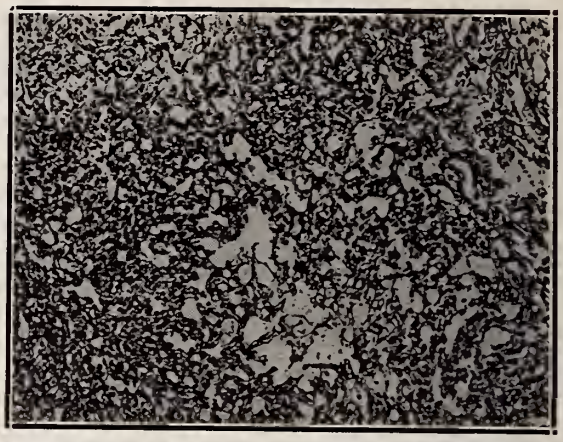


Figure 5. Sarcoma botryoides in infant of seven months.

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DISEASE IS NOT NEWS

During World War II, about 275 thousand men in the United States armed forces were killed, but at home more than twice as many died of cancer alone at the same time. In the same year that the atomic bomb killed 140,000 at Hiroshima and Nagasaki, some 710,000 people died in the United States of cancer and disease of the heart and arteries alone.

SLIPPED DISC

Correction of prolapse without spinal fusion is adequate in most cases of slipped intervertebral disc. Friberg, and Hirsch, recommend subsequent fusion only if disabling pain is unchecked by the first procedure. Six years after complete or partial laminectomy, 44 patients were examined. Prolapse had been found in 37 cases, disc degeneration alone in 5, and no abnormality in 2. At the time of survey, 32 patients were carrying on their preoperative occupation, which in 22 cases was physical labor; 10 had changed to other types of work; and only 2 were not employed. Of the 37 patients formerly suffering from prolapse, 31 were free from sciatic pain and 26 were entirely without low back pain. Symptoms gradually disappear during the first three years after operation, probably because cicatrization decreases mobility of the disc.—*Acta chir. Scandinav. 93:161.*

SUBDURAL HEMATOMA

In infants under two years of age subdural hematomas are more common than generally recognized. In the early stages clots may be removed by aspiration. More than 70% of 150 infants operated on by Ingraham and Matson developed normally. If operation is delayed, irreversible brain damage is so great that the child is grossly retarded mentally.—Modern Medicine 14:46.

ERYTHROCYTE FRAGILITY

A simplified procedure for testing erythrocyte fragility suggested by Strauss and Faigin offers a clear-cut distinction between normal and abnormal erythrocytes. Cells have increased fragility if more than 30 per cent of the erythrocytes are hemolyzed. Blood drawn to the 0.5 mark in a red blood cell pipette is diluted to the 101 mark with Hayem's solution, and in a second pipette with 0.45 per cent solution of sodium chloride. Both pipettes are shaken for a minute or two and an erythrocyte count is made in the hemocytometer by the usual technic. The hemolysis in per cent is calculated from the difference of the two counts. Blood cells from patients with congenital hemolytic anemia consistently show more than 70 per cent hemolysis.—*Am. J. Clin. Path. 16:437.*

SURGICAL COMPLICATIONS OF PREGNANCY *

J. ROBERT WILLSON, M.D., Philadelphia, Pa.

In any group of pregnant women, the need for surgical treatment occasionally will arise. The lesions demanding such intervention are the same conditions which may occur in any non-pregnant woman of like age. The important difference is that the pregnancy may delay the diagnosis until after the ideal period for surgery has passed. For this reason, statistics show higher death rates for surgical operations during pregnancy than for a like group of non-gravid women.

There are also certain changes which are normal for pregnancy but which confuse the picture and delay the diagnosis. Among the physiologic alterations which may make evaluation more difficult are the following:

1. *Change in the blood picture during pregnancy.* Physiologic leucocytosis is present and it is not unusual to observe white blood cell counts that vary between 12,000 and 15,000 in the normally gravid woman. In the immediate postpartum period, the count is likely to be even higher. There also occurs during pregnancy an increase in the sedimentation rate which make this test of little value in its usual interpretation.

2. *Changes in the gastrointestinal tract* which are apparently normal for pregnancy also may be somewhat confusing. In early pregnancy there occurs in about half the patients, "physiologic" nausea and vomiting. This may vary from slight nausea in the morning to constant, severe vomiting which may endanger life and produce marked dehydration and shock. Improvement usually is noted late in the first trimester and by the thirteenth week of the gestation period the symptoms have ceased. True vomiting of pregnancy never begins after the first trimester and in such a patient other causes should be considered first. Constipation and hemorrhoids are commonly noted and this combination may result in rectal bleeding. One must, however, not assume that rectal bleeding in a pregnant patient is on this basis without complete investigation, since occasionally carcinoma of the bowel may be the cause.

3. *Adnexal pain* in early pregnancy may be severe in nature and localized to one side. This can be confused with tubal pregnancy, appendicitis or with acute pelvic inflammatory disease but ordinarily there are no palpable masses, no temperature elevation and none of the other signs of these conditions. Adnexal pain is usually transient and clears up spontaneously. Later in pregnancy, apparently due to the tension on the round ligament, pain localized in the right lower quadrant may be observed. This not infrequently suggests appendicitis or renal pathology; however the tenderness is found to be localized over the easily palpable round ligament and there are no other associated signs of infection.

4. There occurs during pregnancy a *physiologic hyperplasia of the thyroid* and an elevation in the basal metabolic rate to as high as plus 25. Consequently unless there are other signs of pathologic activity diagnosis of hyperthyroidism on the basis of these changes is unwarranted.

SURGICAL LESIONS IN PREGNANCY

Ovarian Cysts. Among the surgical lesions which may complicate pregnancy, one of the most common is neoplasm of the ovary. True ovarian cysts may be encountered in from one in 500 to one in 1500 pregnancies. They are usually benign and unilateral and in most cases the patient is unaware of the fact that she had a pelvic neoplasm before her pregnancy examination. Approximately 50 per cent of the tumors are dermoid cysts. Early in pregnancy the ovary containing the corpus luteum may be enlarged and the examiner may suspect a neoplasm. In such a case, however, the ovary is ordinarily less than five centimeters in diameter and diminishes in size during the first trimester; whereas a true ovarian neoplasm usually is larger and either remains the same size or, in some instances, increases. The decision to remove an enlarged ovary can be made only after it has been proved that there has been no regression in size of the tumor over a period of several weeks.

The dangers associated with ovarian neoplasms in pregnancy are from torsion on the pedicle and infection that they may block the inlet and prevent normal delivery and that an occasional tumor may be malignant.

The ideal treatment of such an ovarian neoplasm is laparotomy with removal of the tumor between the fourteenth and sixteenth week of the pregnancy. By this time the function of the corpus luteum, which may be in the abnormal ovary, has been assumed by the placenta and it is unlikely that abortion will occur.

Tumors not removed at this time may undergo any of the changes noted above. If the

* Read before the Section on Obstetrics and Gynecology, Annual Meeting of The Medical Society of New Jersey, April 27, 1948. This paper comes from the Temple University School of Medicine and Hospital.

tumor is discovered late in pregnancy and is out of the pelvis vaginal delivery followed by laparotomy with removal in the first few hours of the puerperium is the treatment of choice for the normal patient. Early removal is suggested because many of these tumors undergo torsion on the pedicle as the uterus decreases in size following delivery. Should the tumor be found late in pregnancy or in labor and if it blocks the inlet, delivery from below is impossible. If the tumor cannot be displaced, cesarean section and removal at term or early in labor is the method by which the majority are handled. The uterus may rupture if labor is allowed to continue. Puncture and drainage through the posterior cul de sac, particularly of a dermoid, frequently is followed by peritonitis and should not be considered.

Following planned removal of ovarian tumors in pregnancy, it is ordinarily not necessary to supplement with corpus luteum preparations because if the operative procedure is carried out at the proper time there is no longer the need for the ovarian secretion of the hormone.

APPENDICITIS

Appendicitis is no less common during pregnancy than in non-pregnant women, the frequency rate being somewhat under 0.5 per cent. In some instances, the congestion associated with pregnancy increases the symptoms of appendicitis in a patient subject to recurrent attacks. Diagnosis in pregnancy is made on the basis of the history of nausea and vomiting, the epigastric pain which localizes in the right lower quadrant and upon the demonstration of muscle spasm and rebound tenderness. The picture can be confused by the fact that the patient may have nausea and vomiting associated with her pregnancy, and by the fact that there is a physiologic leucocytosis. Remember too, that the upward shift of the cecum by the enlarging uterus may alter the position of the tenderness and pain. The white blood count in the questionable case, if checked hourly will increase both in total count and in the percentage of young polymorphonuclear cells in the presence of infection and will remain unaltered in its absence. During labor and the puerperium the diagnosis is exceedingly difficult to make. At these times, the investigation of any pain in the abdomen requires the most astute of observations.

The differential diagnosis of appendicitis is primarily the elimination of simple round ligament tenderness and urinary tract infection. With round ligament pain there are none of the other associated signs of appendicitis or of infection and it ordinarily is not difficult to eliminate it by simple abdominal palpation. Urinary tract infections, however, may be much more difficult because commonly the initiating sign appears in the right lower quadrant at the point where the ureter enters the pelvis. There ordinarily is, in these patients evidence of infection in the catheterized urine specimen and there is less likely to be muscle spasm and rigidity; gastrointestinal symptoms however, are common.

The treatment of established appendicitis during pregnancy is removal of the appendix. Much of the increased mortality in the past has been due to the fact that operative intervention has been delayed by late diagnosis. The ruptured appendix is treated by operative removal followed by the liberal administration of sulfonamide drugs, penicillin and streptomycin. Fetal loss with widespread maternal peritonitis is high, probably due to anoxemia resulting from the tetanically contracted uterus resulting from the peritoneal irritation.

DISORDERS OF THE THYROID

Since physiologic increase in size of the thyroid occurs during pregnancy, enlargement alone does not constitute enough evidence to warrant thyroidectomy. Nor is slight elevation in the basal metabolic rate an indication for thyroid surgery. Hyperthyroidism during pregnancy presents the same signs and symptoms that might be expected in the non-pregnant patient. Pregnancy usually does not alter the method of treatment. A preliminary period of sedation, Lugol's solution and bed-rest should precede removal of the gland. If the symptoms appear late in pregnancy it is well if possible to delay surgical treatment until after delivery. The danger that the patient may become iodine-fast is always present,

however, and the optimum time for surgical intervention should not be allowed to pass simply because of the pregnancy. The place of thiouracil in the treatment of hyperthyroidism in pregnancy is not as yet established.

GALLBLADDER DISEASE

Although gallbladder disease occurs more frequently in the female than in the male, it is not a common complication of pregnancy for in most instances it first appears after the completion of childbearing. Gallstones do not result from pregnancy; in fact, they are no more common in parous than in nulliparous women. The diagnosis of gallbladder disease is made on the basis of a history of intolerance to certain foods, upper right quadrant pain, nausea, vomiting and episodes of jaundice if they have been present. Cholecystography may be helpful in making the diagnosis of gallstones except late in pregnancy when this examination is unreliable because the fetus may overlie and obscure the gallbladder. Gallbladder disease must be differentiated from the nausea and vomiting of early pregnancy; and in late pregnancy from pre-eclampsia in which the patient may have nausea, upper abdominal pain and tenderness over the liver. The treatment of gallbladder disease in pregnancy is adjustment of diet and the use of antispasmodic drugs. Only in the patient who is incapacitated by the disease, in whom medical treatment fails or in whom there is an immediate need for surgery should it be undertaken; such patients include those with common duct stones, frequent disabling attacks, or acute empyema of the gallbladder. Obviously surgical intervention is much simpler in early pregnancy than when the abdomen is distended by the gravid uterus.

INTESTINAL OBSTRUCTION

Intestinal obstruction is not common but may occur as a result of the increasing size of the uterus and tension on an adherent loop of bowel. This should be suspected in any patient who has had previous inflammatory disease or abdominal surgery who develops vomiting, distention and obstipation during pregnancy. It may be confused with the more severe types of nausea and vomiting occurring in early pregnancy but any vomiting during pregnancy which begins after the first trimester is due to something other than the pregnancy and obstruction may be one of the responsible conditions. The value of x-ray examination depends upon the stage of pregnancy and the size of the uterus.

The treatment of intestinal obstruction during pregnancy begins with relief of the distention by the use of the Miller-Abbott tube with surgical intervention reserved for those in whom the obstruction cannot be overcome by the more simple means. There should be, however, no hesitancy in opening the abdomen of an obstructed patient if she fails to respond to conservative management or if it seems likely that nonsurgical treatment will prove ineffective.

URINARY TRACT PATHOLOGY

Urinary tract pathology may constitute a serious complication of pregnancy. The surgical lesions encountered are primarily old pylonephritis with renal destruction and acute exacerbations of the infection, renal tuberculosis or large staghorn calculi with infection and renal failure. In such cases, particularly if the kidney on the involved side is non-functional, a nephrectomy may be the treatment of choice. If the remaining kidney is normal in its function it is unusual for the pregnancy to be disturbed.

CARCINOMA OF THE CERVIX

Carcinoma of the cervix is an uncommon but important complication of pregnancy. It will not be diagnosed unless the physician is first aware of the possibility. The signs of carcinoma of the cervix are: painless, bright red, vaginal bleeding, progressive in amount which usually follows trauma. Such bleeding is commonly attributed to threatened abortion and the patient is not examined but kept in bed for weeks or months in an attempt to conserve the pregnancy. It should be a rule that if bleeding in early pregnancy continues for more than a week aseptic bimanual and speculum examination be carried out. Any areas of the cervix which may bleed upon manipulation or which are unusually proliferative should be biopsied. Physiologic changes in the cervix associated with pregnancy are likely to be confus-

ed by the inexperienced pathologist with malignancy and it is important that all biopsied material from such patients be examined by a pathologist who is experienced in the diagnosis of gynecologic lesions. The treatment should be directed by a competent gynecologist and consists primarily of irradiation with deep x-ray and radium. If the lesion is discovered near term, it is well to deliver the patient by cesarean subtotal hysterectomy and begin irradiation therapy as soon as the wound is healed.

GENERAL PRINCIPLES FOR SURGICAL OPERATIONS DURING PREGNANCY

ANESTHESIA

General anesthesia in the mother, particularly if there is any degree of anoxia, may damage the fetal brain. Regional anesthesia, if it can be utilized, is safer. If an inhalation anesthetic must be given an adequate supply of oxygen is essential.

ENDOCRINE THERAPY

It seems unnecessary to administer progesterone preparations routinely simply because an operative procedure is carried out in pregnancy. For most procedures there is little or no trauma to the uterus and the endogenous source of progesterone, the placenta, remains undisturbed. It is almost impossible to initiate labor before term by any known means, particularly by manipulation of the uterus incidental to an operative procedure such as cystophorectomy or appendectomy. If the corpus luteum hormone is thought to be necessary adequate amounts, (10 to 15 milligrams daily) should be given.

AMBULATION

Patients need in most cases be kept in bed no longer after operation than they would be if not pregnant. If, however, extensive manipulation has been necessary, ambulation should be delayed for three or four days as an added safety measure.

SUMMARY

Surgical diseases which complicate pregnancy are primarily the common lesions affecting non-pregnant women of the same age. Physiologic changes associated with the gravid state may make accurate evaluation of symptoms more of a challenge to the physician. Since these changes involve primarily the laboratory studies which are commonly used in making a diagnosis, clinical judgment is brought into the foreground as the most important factor in establishing the cause of symptoms. Careful, complete history and physical examination must never be neglected in any patient who may have a surgical lesion. A decision to operate should not be made hurriedly in these patients; but it is equally important that surgery not be delayed if there is an adequate suspicion that it is necessary.

Accurate diagnosis, prompt treatment and improved pre-operative and post-operative care have resulted in a decrease in mortality for surgical procedures during pregnancy.

DISCUSSION

Dr. E. G. Waters (Jersey City): Physicians managing moderate numbers of pregnancies will not frequently see surgical complications. There is a good statistical reason for this. In the first place, not all women become pregnant. And in the second, the average number of pregnancies maturing is about three and one-half per married couple. If the fertile span is considered from 15 to 42, then in these 27 years the average childbearing woman will be pregnant only about 32 of these 324 months. Her chance of having an acute surgical emergency, not related to the pregnancy itself, is only one-tenth the chance of *average* occurrence. And the incidence-chance ratio is further reduced to less than seven per cent for the second and third trimesters, as compared to non-pregnant women. It is at this time that surgery in pregnancy is most difficult. Therefore, it is important to maintain clinical balance by remembering the infrequency of such complications when evaluating the bizarre and confusing clinical picture which any pregnancy-illness may induce.

On the other hand, the relatively greater threat of such complications in the pregnant demands the utmost care in diagnosis and finesse in management. As has been indicated by Dr. Willson, the physiologic initiation of symptoms may so closely resemble the pathologic that only experienced and competent obstetric analysis may differentiate between the two. And the progressive enlargement of the uterus, with increasing visceral displacement and inaccessibility, space restriction and parietal tension, make an operation late in a pregnancy major surgical problems. For these reasons, every pregnant patient with symptoms suggesting a surgical complication should be diligently examined first by an obstetrician, and unless he is also a competent surgeon, then by a surgical consultant.

The physician trained only in obstetrics and obstetrical surgery, has no business dealing with life-threatening major surgical complications with which he is relatively inexperienced.

It is essential to determine whether the origin of the pathology is pelvic or abdominal. Removing symptom-producing ovarian tumors early in pregnancy does not inevitably lead to abortion, even when the corpus luteum is sacrificed. One of my patients who had a bilateral oophorectomy for benign ovarian teratoma at the fifth week of pregnancy, went to term. Another, a 42 year old primipara with the corpus luteum part of a large endometrial tumor, carried to term and normal delivery even though oophorectomy was done during the eighth week of her pregnancy. In my own experience, complications from ovarian tumors are actually more common in the non-pregnant. The pregnant uterus tends to lift the tumor with it into the more capacious abdomen so that complete twisting of the pedicle with pelvic incarceration, suppuration and intracystic hemorrhage is less often seen. As Dr. Willson has said, treatment depends upon presenting symptoms and the period of pregnancy although all such tumors are ultimately headed for surgery. Almost all of the ovarian tumors are benign. Concurrent pregnancy and ovarian cancer is extremely rare. I have seen only two cases of ovarian cancer with pregnancy, (one a melanoma). They may be considered rarities of little clinical importance except to the unfortunate victim.

The incidence of abortion, premature labor, tumor necrosis, adherent and retained placenta, and postpartum hemorrhage is higher in patients with fibroids. So-called "red degeneration" is not rare but seldom needs radical interference. I have found myomectomy necessary during pregnancy in only three patients in the past fifteen years, and all three went to term. When the tumors are lower segment and obstructive, or numerous in elderly primipara, cesarean-hysterectomy is often needed, although I believe that vaginal delivery and delayed operation are better for most of these patients. A conservative myomectomy may permit to go through future pregnancies successfully.

Fundal cancer is a curiosity and cervical cancer has occurred in only five of our 100,000 deliveries. This co-existive rarity is due to the differential in the reproductive age and the cancer age. Early detection of cervical cancer will never be attained until physicians abandon the silly habit of not examining patients who are bleeding. Every pregnant patient who is bleeding needs an examination of the cervix. A careful speculum examination will *not* cause abortion.

Rectal cancer early in pregnancy does justify abortion and it usually requires a radical attack on the lesion. Fewer than eighty such cancers, however, have appeared in the literature of obstetrics, so they are uncommon.

Unexplained shock and symptoms of postpartum hemorrhagic collapse have led to operative discovery of ruptured uterine and broad ligament varices in two of my patients. This possibility should not be forgotten.

The two chief life-threatening surgical emergencies of pregnancy originating in the abdomen are appendicitis and intestinal obstruction. Acute cholecystitis is well handled by chemotherapy and antibodies. With the rare exceptions of common duct stone and empyema, gallbladder surgery can be deferred until the pregnancy has terminated.

Pregnancy augments the difficulties and dangers in diagnosis and treatment of acute appendicitis, although it does not increase its incidence. The few numbers of pregnant months in the average female life account for the infrequency with which it is seen, but in no way lessen its danger. If pressure is placed upon the left side of the abdomen displacing the uterus gently but positively to the right, there is marked pain production in the right iliac fossa in acute appendicitis, due to direct pressure on the inflamed viscus and the cecum. The pain which the shift of the uterus to the right induces is relieved gradually as the directing pressure from the left is lessened, but may be reproduced at will. In conjunction with all of our usual diagnostic aids, it is a most valuable asset in differentiating between appendicitis in pregnancy and its great imitators, pyelonephritis and ureteral stone, since with the latter, there would be no induced somatic response nor protective spasm.

It is important at operation to remove the appendix and leave the uterus strictly alone. It is a breech of surgical sense to do a cesarean section at the time of appendectomy, regardless of the type of appendiceal pathology encountered. This was true even before sulfonamides and penicillin, and with these as integral parts of our therapy, the last arguments for concurrent appendectomy-hysterectomy should go overboard. If labor follows operation, it should be shortened by prophylactic forceps under analgesia with terminal low spinal or local anesthesia. Meanwhile, penicillin and other therapy lessen the danger of hematogenous infectious spread to uterus and fetus. If the patient is at term or in labor when appendicitis is diagnosed, and there are sound obstetrical indications for cesarean section, the operation should be done extraperitoneally, *first* through a low left paramedian incision. At completion of the operation, the appendix is approached through an independent McBurney or right pararectus incision. This obviates gross uterine contamination and reduces uterine size by delivery of the fetus before appendectomy. Drainage, if needed, is well away from the cesarean wound.

Intestinal obstruction in pregnancy is rare, and its very infrequency jeopardizes the patient's life. One may be misled, either by the years elapsed since the last surgery, or by one or more interval uncomplicated deliveries. X-ray diagnosis is notably inefficient in these patients and may be positively misleading. Non-surgical drainage with Miller-Abbott and similar tubes can lead to false security while bowel necrosis proceeds apace. Early operation, as in all patients with positive evidence of intestinal obstruction, takes precedence over procrastination.

In thyrotoxicosis complicating pregnancy, operation may be postponed until after delivery, and in many cases rendered unnecessary, by the use of propyl-thiouracil. Just as the toxemia is enhanced and worsened by the increase in physiologic basal needs of pregnancy, so is the improvement more marked after parturition. I have had only limited experience with this treatment, but it has been encouraging. The treatment is selective in that its most hopeful application does not include thyrotoxicosis secondary to adenoma where Lugol's solution is used purely as a pre-operative therapy.

In the more common thyrotoxicoses or diffuse glandular hyperplasia, its effect is startling.

Usual dosage is 50 milligrams three times a day for two weeks, then once or twice daily until metabolic rate is normal, when daily administration of 25 milligrams is sufficient. Dessicated thyroid, a half to 1½ grains daily, is recommended to check the tendency to excessive glandular hyperplasia. This makes it possible to defer surgery until the pregnancy is over. Then the true degree of hyperthyroidism can be reckoned. Indeed, in some instances, a medical cure will have been obtained.

THE CANCER PROBLEM IN PROCTOLOGY*

Frank S. Forte, M.D., Newark, N. J.

According to figures of the American Cancer Society, New Jersey Division, in Essex County alone 3156 deaths were caused by cancer of the digestive organs and peritoneum during the five year period ending in 1944. An approximate idea of the local distribution of these figures can be obtained by indirect computation. To begin with we know that the bulk of gastro-intestinal tract cancers occur in the large and terminal bowel. We may, therefore, assume that the majority of these deaths were due to cancer of the rectum and sigmoid colon. This is substantiated in analysis of large bowel malignancy distribution done by such authorities as Lahey, Bacon and others. The following is such a study.

In a series of 817 cases of carcinoma of the large bowel, Jackman and Waugh of Mayo Clinic report the following distribution.

Cecum	4.2%
Ascending Colon	3.7%
Hepatic Flexure	2.3%
Transverse Colon	4.1%
Splenic Flexure	2.3%
Descending Colon	5.4%
Sigmoid	17.1%
Recto-Sigmoid	0.6%
Rectum	46.2%
Anorectal	3.7%

The fact that the bulk of these cases occur in the rectum and sigmoid serves to re-emphasize the importance to us of thorough digital examination as well as proper visualization. In spite of the ease with which most of these lesions are either palpated or visualized many are still treated for some condition unrelated to the carcinoma. It must be remembered that discovery of a polyp in the rectum should be followed by thorough colonic x-ray study. Not infrequently other polyps and even a malignant lesion are to be found.

FURTHER AIDS IN DIAGNOSIS

1. *Biopsy* is still of major importance and care must be exercised in removing tissue that the site chosen for study includes actual tumor structure. One must also be gentle in manipulation and use an adequate instrument. Serious hemorrhage is not impossible. With the biopsy specimen, the surgeon should submit information regarding the history of development of the tumor, physical characteristics and size of tumor, data as to previous therapy, previous tumor history and patient's present condition. The pathologist should reply with an easily understood report and with a prognosis if possible from the histologic findings.

2. *Papanicolaou* states that the diagnostic value of his smear test is based on the fact that malignant neoplasms having a free surface are constantly exfoliating i. e., there is a continuous spontaneous curettage. The detached cells may be single or in clusters: basis of diagnosis may be structural as well as cytologic. Efforts are now being made to apply this method to some malignancies of the lower bowel.

3. *The Bolen test* depends on the fact that drops of blood dried satisfactorily on a glass slide form a pattern which is a sensitive indica-

* Read by invitation before the N. J. Proctologic Society, October 14, 1947.

tor and can be used at intervals to determine the course of the disease, the presence of metastasis, and the end results after surgery, deep x-ray therapy or radium implantation. In the *normal* patient, the pattern is characterized by appearance of well formed fibrin strands varying in size and thickness and crossing one another in all directions so as to form a fibrin web enmeshing the corpuscles. In *early carcinoma,* it shows a change in fibrin formation and the presence of small areas of plasma without red blood cells. In *carcinoma,* there is a definite marked change in fibrin formation and the presence of large areas of plasma and absence of red blood cells. The pattern is constant in malignancy and has no relationship to anemia when present.

The same pattern is formed on the slide by cancer blood and by the blood of pregnant women. Just before delivery the blood begins to revert to normal. This same "return to normal" is seen in cases of cancer in which total extirpation has been achieved, although the process takes about six weeks. Needless to say, tests such as these could be of inestimable value in tumor screening work.

MANAGEMENT OF THE CASE

Having finally arrived at a definite diagnosis of malignancy what shall our procedure be?

First we are confronted with social and economic problems. Typical questions arising are: Who is paying the hospital bill? Who is going to support the patient during the period of convalescence? Is the patient the bread winner? If so, what method shall be chosen to expedite his or her early return to gainful employment. Nursing care post-operatively and through the convalescence period poses still another problem.

Second: What is the actual treatment to be? The answer to this depends largely on the local view point.

Views on colonic surgery are in a state of flux. For example authorities such as Jones and Babcock have completely divergent views on handling low left sided lesions. Jones will never do a "pull through" operation. He prefers the Miles procedure. Babcock has stated in no uncertain terms that he has not done a Miles operation in 17 years. He is the prime exponent of the "pull through" operation; a method espoused and successfully carried out by Bacon also.

Training, experience and keen interest certainly decide the question of procedure. The trend, however, is toward complete resection of the lesion. This immediately poses the next question: what constitutes "resectability"? A lesion that can be mobilized regardless of the liver or gland involvement is a "resectable" growth.

For the case that is beyond resectability the usual palliative simple colostomy can be done.

Exclusive of the upper sigmoid lesions (that generally can be handled by resection and then "end-to-end anastomosis") whatever our procedure may be we acquire a colostomy patient. In most cases, a colostomy can be managed by diet, hygiene and mental attitude without much trouble if we make the effort needed to train the patient. But let it be remembered that a poorly functioning or profusely draining colostomy can create a social outcast because of fancied or actual offensive conditions associated with it. Exponents of complete eradication feel that many of these instances are due to palliative colostomies done where the cases were really resectable. Hence foul, sloughing, bloody discharge plague the patient and deprive him of a possible so-called five year cure.

Aside from improved technic, the preoperative and post-operative preparation, transfusions, use of sulfonides and antibiotics have aided materially in achieving our present improved level of colonic surgery. However, x-ray and radium therapy, have, to date been of little or no help.

SUMMARY

1. Biopsy is still our important diagnostic aid.

2. The doctor must understand the economic and social sides of the problem as well as the surgical procedure.

3. The Papanicolau and Bolen tests have possibilities as diagnostic aids.

4. Advances are being made in colon surgery through preoperative preparation sulfonides, antibiotics, as well as in good technic.

318 Roseville Avenue

STATE ACTIVITIES

ROLE OF A MUNICIPAL HEALTH DEPARTMENT IN A MEDICAL CARE PROGRAM

This is an abstract of a talk given at the School of Public Health, Harvard University, April 22, 1948, by Dr. Charles V. Craster, Health Officer of the city of Newark. A limited supply of copies of the full talk are available on request directed to Dr. Craster at 94 William Street, Newark 2, N. J.

In Newark for the past half-century, we have accepted the principle that medical care of the indigent is a function of the city health department. This divides itself into two operational divisions: clinic care and home care. We have found that clinic care is the only practical way of administering ambulatory medical service to the indigent. We did try a system of allowing indigents to receive care in the private offices of their doctors at government expense. This was during the days of the Emergency Relief Administration, and under this arrangement, costs skyrocketed to such an extent that the whole program fell into disrepute.

Until five years ago, care in the patient's home was furnished by salaried district physicians. This proved unsatisfactory from the standpoint of patients, physicians, and government alike. During times of economic stress the demand for home visits became overwhelming. The patients had no choice of physician, and were too often discourteous or even hostile to the "Poor Physician" who was assigned to them. Most of the doctors were being paid $1200 a year and this meant that each practitioner was receiving about thirty cents a call. This was degrading, demoralizing, and tended to debase medical fee standards throughout the community. With few exceptions, the doctor's own attitude towards a salaried job like this was an attempt to minimize the service rendered. This can be understood when one considers the excessive calls for treatment made on these district physicians at certain seasons of the year. The "off period" when calls are infrequent, was too soon forgotten by the salaried practitioners.

A new day began in 1943 when the city signed an agreement with the medical service administration maintained by The Medical Society of New Jersey and chartered by the state legislature. Selected representatives of the Essex County Medical Society constituted a liaison or conference committee to iron out difficulties, take care of problems concerning the conduct of specific physicians, and rule on disagreements concerning fees, authorizations and frequency of treatment. The latter represents one of the real problems in administering a home care program on a fee-per-visit basis. Some physicians, fortunately few in number, do tend to make unnecessary visits, and it has been necessary for the Department and the medical society's committee to come to some agreement as to a reasonable frequency in various diseases. In serious illnesses, the doctor is expected to make only a single visit and then refer the patient to a hospital. The program is flexible enough to permit of exceptions when home treatment throughout the course of a serious illness will be authorized. A similar plan is followed in obstetrical cases, and we can pay for deliveries at home if there is some good reason why hospitalization could not be effected for the delivery. In chronic diseases, the usual authorization is two visits per week, with special authorizations for more frequent attention during acute exacerbations or intercurrent illnesses. If there is any reason to suspect overtreatment, the matter is brought before the conference of medical society representatives.

In determining an applicant's eligibility for care under this program, we proceed this way. If the patient is on relief, he and his family are almost automatically eligible for participation. If he is not on relief, we clear the family through the social service exchange, and if the family has been investigated by any social agency, we get the complete information promptly. When this does not give us the necessary information, we authorize a single visit, but before the second treatment is allowed we have the application investigated by experienced workers from the Department of Public Welfare who have been detailed to us specifically for this project. In general, we take the position, that for a family of four with an income in excess of $50 a week, eligibility for this program must be denied. However we recognize the possibility of special situations, and therefore individualize each application, and decide each on its own merits.

The present fee schedule calls for a payment of $3 per day call and $5 per night call. These fees are not fixed permanently, but are reached by mutual agreement between the city and the

Medical Service Administration. The fees are subject to change by negotiation and will be changed to conform to varying economic conditions and other factors. The yardstick will be the prevailing private practice fee schedule in the community. The doctor sends his bill to the Medical Service Administration which, in turn, forwards it to our Health Department. If the patient is on the relief rolls, we send the bill to the Department of Public Welfare where the voucher is issued. If the patient is not on relief, but is considered eligible for this plan, the Health Department pays the bill. There is an extra payment of 10 per cent to the Medical Service Administration for their administrative costs. We send an aggregate monthly check to Medical Service Administration which renders payment to the participating physicians individually.

The Department of Health maintains 24 hour telephone service. A relief client who calls in, is instructed to call his own doctor for a first visit. If the patient is not on relief, our Social Service Bureau gives a preliminary authorization for the first visit. Subsequent calls in either category are subject to approval by the Department. If it later appears that the patient had misrepresented his status, the family is billed by the city, and the name enrolled in a special list of ineligibles.

We also make available a limited amount of bedside nursing and, in indicated cases, a visiting housekeeper service. Prescriptions are ordinarily filled at the City Dispensary, but in off-hours, the patient may bring the prescription to any pharmacist who will be paid the cost of the drug either by the Health Department (in non-relief clients) or by the Department of Public Welfare (if the patient is on the relief rolls of the city). We agree with Dr. Parran who, in a recent article, pointed out that "the broader scope of public activity belongs to an age when dynamic new scientific frontiers are opening and new concepts of social responsibility are emerging throughout the world".

Summary: Newark Health Department for many years used a staff of district physicians with annual salaries, to visit the sick poor who could not visit clinics, with the result that:

a. Family had no free choice of physician; had no confidence in the physician and often abused and insulted him.

b. In rush periods of illness a physician was overworked and received a pittance per call; he could hardly be expected to be enthusiastic in his work.

In 1943 that system was changed; family now has free choice of physician. If on relief the Relief Department pays and if not on relief but medically indigent, Health Department pays. The medical society is given monthly payment and pays physicians directly. The Society and the Health Department representatives cooperate to regulate and prevent abuse by patients or doctors. As a result patient is pleased and has confidence in the doctor; the physician gives the same service as to any other patient and is paid a proper fee, payment of which is certain, and strange to say the system works smoother and is costing less than the previous unsatisfactory arrangement.

DIABETES DETECTION DRIVE

Believe it or not, a million Americans are walking around today not knowing that they are victims of diabetes. This startling conclusion is based on projections from sample studies made through diabetes detection drives in various parts of the country. For instance, in Jacksonville, Florida, 3169 presumably healthy persons were routinely checked for diabetes. The result: 47 new, previously undetected, cases of diabetes were found. Again, in Brookline, Massachusetts, fifty cases of diabetes resulted from a routine survey of 3650 presumably undiseased subjects.

Spurred by these findings, the American Diabetes Association, together with its many affiliated associations, has launched a national diabetes detection drive.

All professional persons pledged to the improvement of health are, of course, essential cooperators in this project.

More efficient, more swift, more economical methods of performing blood sugars are in the cards. A simple routine office procedure may soon be available.

Meanwhile, every practitioner who takes his profession seriously, every doctor genuinely dedicated to the protection of health, will want to participate in this drive. Do post-prandial urine sugar and blood sugars on all patients, with a double check on obese subjects and on relatives of known diabetics. In New Jersey alone, such a net should pick up more than 40,000 previously unrecognized diabetics. And it will—if every New Jersey practitioner does his share. Start today!

George M. Knowles, M.D.,
For the New Jersey Diabetes Association

WHAT'S HAPPENING IN BRITAIN?—

A LESSON FOR THE UNITED STATES

The tragedy that has befallen the British medical profession under socialization offers a clear lesson as to the dangers of government medicine in the United States. So declared Dr. Warren H. Cole of Chicago in an address delivered November 18 before the Federation of Employees' Benefit Associations. Dr. Cole, a leading surgeon and a faculty member at the University of Illinois College of Medicine, recently returned from a three months' visit in England as a member of the American Department of State medical mission. He made a thorough study of the effect of the new National Health Service Act during his work there.

"Any advantage that might be put forward to justify the operation of medical service by government is immediately neutralized by the fact that the quality of medical care promptly nosedives," Dr. Cole said. "There are several reasons why that happens.

"First, the number of office visits increases tremendously. That has already happened in England since the N.H.S.A. went into effect last July. Since doctors are already overwhelmed by present demands on their time, they obviously do not have time to examine all patients thoroughly. Unfortunately, the patient who makes the loudest complaint will be most likely to receive attention. That means that patients with many serious diseases, such as diabetes, pernicious anemia, tuberculosis, intestinal cancer, which require careful diagnosis, are neglected until it is too late.

"Again, the doctor has no incentive to do good work. There is no financial reward in sight and the stimulus of competition is eliminated. Even Soviet Russia realizes the value of competition in medicine. And, if one doctor consciously tries to maintain the quality of his work, patients immediately transfer themselves to his panel, so that he no longer has time for patient study.

"A third factor is that, when patients, thinking they are not paying for medical care, crowd the doctor's time with troubles they would otherwise disregard, the doctor becomes disgusted with practice and becomes lax in his vigilance for serious disease.

"Fourth, most doctors are unhappy and dissatisfied with socialized medicine, with resultant deterioration in their efforts. It is impossible to get good service from such doctors."

Another important and tragic result of socialization, Dr. Cole said, is the destruction of the doctor-patient relationship. Since the doctor has no incentive and is too busy anyway, he will not take the time to talk to a patient about his problems, especially those emotional and mental intangibles which affect health, but cannot be quickly identified as physical symptoms can.

"This," said Dr. Cole, "obviously leads to undermining of the patient's confidence in his physician and tends to develop unhappiness and uncertainty in the mind of the patient regarding his medical care."

Under government medicine, too, Dr. Cole continued, the patient in England has little choice of doctors. He can only ask for a specific doctor if that doctor's panel is not full.

Government confiscation of hospitals in Britain destroys community interest in the institution, Dr. Cole said, while the increased demand for hospital beds by undeserving patients makes it more difficult for really sick persons to be accepted as patients.

Government medicine, aside from its evil effects, is not necessary in the United States, Dr. Cole said, though some form of compulsory medicine is part of the program of President Truman. Adequate voluntary health insurance reduces the cost, which is the major factor in support of such programs, and the freedom of American medicine has made its service to the public the best in the world, he said.

PSYCHOSURGERY

A Talk by WALTER FREEMAN, M.D., Washington, D. C.

THURSDAY, JANUARY 13, 1949—8:30 P. M.

VETERANS HOSPITAL, LYONS, N. J.

All physicians are invited to hear this interesting description of one of the world's most-talked about surgical procedures, presented by one of the country's pioneers in psychosurgery. For directions as to how to drive to Lyons, write to the Manager at that hospital.

RURAL HEALTH PROGRAM OF THE WOMAN'S AUXILIARY

Abstracted from a talk given by Mrs. Yaguda October 20, 1948, before the New Jersey Health Congress

When the Auxiliary first planned a program of rural health education numerous persons told us that New Jersey had no truly rural districts, and that our program was unnecessary. "Why aren't the country sections of New Jersey termed rural?" we asked. "Because everyone in the farm families, except mother and the children, work in the city", was the answer.

Staying with our plan, we decided if we could do nothing else, we would give mother and the children some health information, and concern ourselves with proving the need for our program sometime later.

Some doubt crept into our minds when we attended the American Medical Association's Conference on Rural Health last February. Even the act of signing the register as a visitor from New Jersey to the Rural Health Conference was a bit embarrassing. During the proceedings of the first day we could not fit one of the definitions of a rural area to any county in our closely populated, industrialized New Jersey. How compare the health needs of Washington County, Colorado with Hunterdon County, New Jersey?

But when we heard accounts of the inequalities of school health services in urban and rural areas, we felt on familiar ground. We had discovered in carrying out the New Jersey Auxiliary project last year, the formation of county councils for the improvement of school health services, that the child in the city school has many health advantages over the child in the country school.

The Auxiliary plays a subordinate role to the Medical Society. The backgrounds of our members vary from that of an opera singer to that of a home girl who can make a better pie than mother used to bake. Despite this difference, we join together in an effort to create a partnership, between the medical profession and the people, aimed at a constant improvement of health and medical care. We are imbued with the thought of community advancement—it comes to us with our marriage to physicians. As an organization, we work only under the direction of our medical societies. Our chief activity is the dissemination of health information to the laity.

The answer to one important question came from the Medical Society: there has been no request from the rural counties for additional physicians. Our ratio of physicians is 1 to 835 of population on a state wide basis; and this varies from 1 to 622 in Essex to 1 to 1281 of population in Salem County.

The New Jersey farmer, like all farmers, is an independent person—a free enterpriser. I quote from a letter written by an official of a large rural organization: "Many leaders are fearful of giving up home rule even when it is definitely associated with horse and buggy days". Most people realize that there is much room for improvement in the public health facilities of their counties, but they are jealous of their autonomy, wary about extravagant spending and convinced that the movement for betterment of health conditions should originate in their own communities. Residents of the rural areas of New Jersey, cannot, for the most part, be expected to know what should be provided to attain adequate public health services. Our program would provide this knowledge; but would information be acceptable to these people coming from our organization?

The Committee solicited the aid of outstanding farm groups in its attempt to reach the people, the New Jersey Farm Bureau, The Women of the New Jersey Farm Bureau, The Grange and the United Milk Producers Association. Through their executive positions, and personally, the officials of these organizations by their cooperation, insured the success of our introductory meeting, held last June 7. The sponsorship of these groups transformed our program from an abstract plan to a community venture.

Five 'farm hour' radio broadcasts brought the news of the meeting right to Mrs. Farmer Brown's summer kitchen. Speakers were invited from among the home folk, and were given opportunity to talk things over with state and national authorities.

Two thousand invitations were sent out through our county Auxiliaries to selected individuals and organizations. We had a 'roving' attendance of 500 people. Some came to listen to a personality like General Paul R. Hawley lead a discussion panel on "Insurance Against the Costs of Serious Illness". There they found two friends talking it over with General Hawley: Mrs. Robert Crane, president of The Women of the Farm Bureau, and Dr. Hector Irack, representing the State Grange; together with Dr. Norman M. Scott and Mr. J. Albert Durgom, the state authorities on Blue Shield and Blue Cross Plans.

The door had to be closed to the room which housed Dr. Haven Emerson's panel on "Bet-

ter Public Health for Rural New Jersey" long before the discussion was slated to start. There, a capacity crowd was participating with Assemblyman Amos F. Dixon, Miss Winona Darrah, Dr. Chester Ulmer from Gloucester County, Mr. Lloyd B. Wescott from Hunterdon County and Mr. William H. MacDonald of the State Department of Health. And we had Dr. F. W. Cyr leading a discussion on "Prevention of Farm Accidents" with a group of participants which included Mr. R. P. Winters, State Leader of the 4-H Clubs.

Commissioner Sanford Bates had an 'elbow room only' crowd interested in the problems of the chronically ill.

The paper which Dr. Bergsma delivered to our audience, and over radio station WTTM has been widely publicized. His message, which so plainly shows his understanding of rural county health needs accomplished in one day what our organization, together with many others, could not hope to achieve in months of contact at the community level.

Some time has passed since the Conference and we continue to receive expressions of satisfaction from many individuals and organizations. Our plan is a simple one. We shall, through our county Auxiliary groups, together with co-sponsoring agencies, submit a choice of six health subjects as informative and entertaining programs to members of rural organizations, i. e., granges, church groups, P.-T.A.'s, women's clubs, high schools, and civic and municipal associations. Our Auxiliary speakers will appear before an audience of any size, presenting papers approved by our medical society. If an organization anticipates having a fair attendance, or cares to join with another group to create a good sized audience, we will supply a physician or other qualified speaker on the chosen subject. In addition to the speaker, an exclusive moving picture film will be shown; we will have a simple portable exhibit and plenty of pamphlet material to take home.

We are now forming executive committees at the county level, which will comprise a representative of our county Auxiliary, her Medical Society Adviser, the county Home Economics Agent, the ranking officer of the county organization of The Women of the Farm Bureau and one of the county health officers. It will be the responsibility of this County Executive Committee to obtain bookings for the individual programs. The Auxiliary is supplying the woman-power; our co-sponsoring agencies, the physical features of the programs.

Here are the subjects, with the sponsoring groups indicated parenthetically:

Prevention of Rural Accidents (State Safety Council; Rutgers University).

Better Public Health (N. J. State Department of Health).

Rural Sanitation (N. J. Health and Sanitary Association).

Insuring the Cost of Serious Illness (Medical-Surgical Plan; and Blue Cross).

Health of the Preschool Child (American Academy of Pediatrics).

Does Your Community Need More Hospital Facilities? (N. J. Hospital Association; and State Department of Institutions and Agencies).

Among our cooperating associations are the New Jersey Congress of Parents and Teachers, New Jersey State Department of Conservation, Forest Fire Service, The New Jersey Farm Bureau, and The State Organization for Public Health Nursing. These cooperating groups have publicly endorsed the principles of our program, or intend to assist the program by supplying pamphlet material, or aid in obtaining bookings for the program. (The Committee respectfully solicits the endorsement of the member organizations which make up the New Jersey Health Congress.) The organizations which endorse the principles of this program will be listed as "Cooperating Organizations" on the program brochures which will be widely distributed throughout the state.

The Committee has suggested to our county Auxiliary groups that a series of county-level rural health conferences might be acceptable. We feel, however, that although the county Auxiliaries would gladly set up these meetings. the request for such gatherings should emanate from the residents of the counties. The first of these is to be held in Hunterdon County, where a group of private citizens, together with the county medical society and its Woman's Auxiliary are making plans to call together the people of Hunterdon to hear a discussion of the public health needs of that section. We hope that Hunterdon will get its hospital.

The officers and the executive board of the State Auxiliary gratefully acknowledge our debt to the individuals and agencies which have so generously assisted in this program.

We who have planned this program are not unmindful of the fact that, given an informed public, together with these and other approved health agencies at the local level, we have the beginnings of that fine new American institution, the community health council.

Mrs. Asher Yaguda, Chairman,
Public Relations Committee
Woman's Auxiliary to
The Medical Society of New Jersey

SUPPLEMENTARY LIST No 7
TO THE
1948 OFFICIAL LIST OF MEMBERS

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Abramson, Harry, 14 W. Young st., Somerville (18)
Andrews, Thomas H., 263 Bath ave., L. Branch (13)
Berkow, Bori, 245 State st., Perth Amboy (12)
Blecher, Irving E., Veterans Hospital, Lyons (18)
Borino, John W., 15 Washington st., Newark (7)
Brundage, Robert H., 14 Northfield rd., W. Or. (7)
Gerwanter, Aaron P., Somerset Co. H., Som'rv'e (18)
Graft, Richard S., 44 Green ave., Madison (14)
Higgins, Eugene V., 1180 Raymond Blvd., New'k(7)
Kant, Emanuel R., 240 High st., Perth Amboy (12)
Kraemer, Louis B., 74 Baldwin ave., Newark (7)
Kralik, Joseph J., 555 Market st., Newark (7)
Leonard, Martha F., 55 N. 5th ave., Highland P.(12)
Mazur, Stephen H., 557 Grove st., Irvington (7)
McCullough, John H., 523 E. State st., Trenton (11)
McGurl, Frank J., Prudential Ins. Co., Newark (7)
Mick, Edwin C., 46 S. Burnett st., East Orange (7)
Miller, Clark F., c/o Central Maine General Hospital, Lewiston, Maine (12)
Modny, Michael T., 262 Ridgewood ave., G. Ridge (7)
Pickar, Gabriel, 205 N. Second ave., Highland P.(12)
Rubin, Henry S., 11 High st., Morristown (14)
Rubino, Nicholas M., 235 Roseville ave., Newark (7)
Stollman, Bernard D., 21 John st., N. Brunswick(12)
Thetford, Norman D., 68 South st., Eatontown (13)
Van Dyke, Laura V., 125 Hamilton st., B. Brook(18)
Weinstein, Alvin A., 710 Mattison ave., Asb y P.(13)
Wilson, Jon M., 125 Hamilton st., Bound Brook (18)

ASSOCIATES

Brinning, Emanuel C., 442 Wash'gt'n ave., M'tcl'r(7)
Dasher, Wylly M., 320 Park ave., Orange (7)
Dwulet, Leon J., St. Home for Boys, Jamesb'g (12)
Harms, Charles R., 363 Park st., Montclair (7)
Hutchinson, Harry F., 209 Passaic ave., Spr. L. (13)
Novak, Edward J., 61 Green st., Woodbri ge (12)
Tyndall, Alice D., 127 Maple ave., Red Bank (13)
Wiley, Herman O., 160 Monmouth st., R. Bank (13)

PENICILLIN FOR AMBULATORY TREATMENT OF SYPHILIS

A change in the plan of providing penicillin for the treatment of syphilis has been made since the announcement was published in the November JOURNAL. At present P. O. B. (penicillin in oil and beeswax) is being sent by the Division of Venereal Disease Control to physicians who request it for the treatment of both early and late syphilis. The physician must report the case, noting on the back of the report card that penicillin is requested. Two vials, 10 cubic centimeters each, of the P.O.B. will be sent on receipt of the report card. This penicillin is fluid enough to be used without heating, and although newer preparations are on the market, this is a perfectly satisfactory product.

NEW JOURNAL OF STERILITY

A new journal entitled "Fertility and Sterility", sponsored by the American Society for the Study of Sterility, will be available for circulation next month. Subscription is $7.50 per year. The journal will be edited by Dr. Pendleton Tompkins at 450 Sutter Street, San Francisco 8. Original papers should be sent to Dr. Tompkins at that address. Subscription remittances should be sent to the publisher, Paul B. Hoeber, 49 E. 33 Street, New York City 16.

INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES

For the first time in world history an International Congress on Rheumatic Diseases will be held in the United States. This four-day session will open at the Waldorf-Astoria in New York City on May 30, 1949.

OBITUARIES

DR. RAYMOND D. BAKER

Dr. Raymond D. Baker of Summit, was killed in an automobile crash in North Carolina on November 3, 1948.

Considered by his colleagues a leader of Summit physicians, Dr. Baker was born in Auburn, N. Y., in 1878. He was graduated from Bellevue Medical College in 1899, and during his early life practiced in New York City. He moved to Summit after serving as resident physician at Greystone Park from 1900 to 1904. In 1906 he became a visiting physician at Overlook Hospital and later headed the hospital's department of medicine. At the time of his death he was consultant. At one time he was an instructor in medicine at New York Polyclinic Hospital.

Dr. Baker was a charter member of the New York Gastro-Enterological Society and was a former Summit school doctor.

DR. JOSEPH H. BRYAN

Dr. Joseph H. Bryan, senior honorary member of the Monmouth County Medical Society, died at the Fitkin Memorial Hospital on October 21, 1948. Generally considered the dean of practitioners at the north Jersey shore, Dr. Bryan was widely known in Monmouth County, not only as a physician, but also for his activities in civic, musical and athletic circles. He spearheaded the drive of the Citizens Association which brought city manager government to Asbury Park. He was an active tennis player to the age of 75, and thereafter took a keen sideline interest in the development of the game. He was leader of the Schubert Glee Club, an active singer in his church choir, and at one time served as secretary of the Metropolitan Conservatory of Music. For 30 years he directed the choir of the First Methodist Church.

Dr. Bryan was born in Newark in 1865, he received his B.A. from New York University, and his M.D. from the New York Medical College in 1890. Three years later he came to Asbury Park, and for a half a century practiced medicine actively at the Jersey shore. He served on the New Jersey State Board of Medical Examiners for 15 years, two of those years as president of the Board. His son, James, is Executive Officer of The Medical Society of New Jersey.

DR. J. LYNN MAHAFFEY

Dr. J. Lynn Mahaffey, who for 17 years served as our State Director of Health, died on November 1, at his home in Haddonfield.

Appointed a member of the State Board of Health in 1925, Dr. Mahaffey became its director in 1931.

Under Dr. Mahaffey's guidance, New Jersey was the first state to ban Fourth of July fireworks. He successfully sponsored legislation for curbing venereal diseases. Other laws he sponsored, many of which were models for other states, included premarital blood tests, rural dental hygiene program, stricter drug regulation, Negro health program, an industrial hygiene program and modernized sewage control.

Dr. Mahaffey was born in Hillsdale, Pa., in 1879. He was graduated in 1902 from the University of Pennsylvania. During World War I he was chairman of Draft Board 1 of Camden.

He practiced medicine in Camden more than 40 years. From 1910 to 1930 he was chief of the medical department of Cooper Hospital, Camden. He was founder of Bellevue Private Hospital in that city, serving as its manager for some time after it was opened in 1919.

In 1935, the American Medical Association elected Dr. Mahaffey a vice-chairman of its Scientific Assembly to serve on the section of preventive medicine and public health. He was president of the 1943-44 Conference of the State Health Authorities of North America. At various times he headed the Camden city and county medical societies.

DR. ABRAHAM ROSE

Dr. Abraham Rose, assistant police physician of Elizabeth, died on October 31, following a ten-day illness caused by a heart condition.

Dr. Rose was a urologist on the staffs of St. Elizabeth and Alexian Brothers hospitals. He was formerly on the Board of Health venereal clinic staff and had been a Police Department physician for the past six years.

Dr. Rose was born in Russia in 1887, but came to this country at the age of 14. Following his graduation in 1914 from Medico-Chirurgical College of Philadelphia, he interned at St. Elizabeth Hospital.

DR. CHARLES B. RUSSELL

Dr. Charles B. Russell, who practiced medicine in Paterson for 42 years, died on October 26 in St. Joseph's Hospital.

Dr. Russell was born in New York in 1876, and received his medical degree from Harvard Medical School in 1904. During the first year of his practice, he did post-graduate work at the Skin and Cancer and Polyclinic Hospitals in New York City. Dr. Russell was assistant surgeon at the New Jersey Orthopedic Hospital, Orange, for more than 25 years. He also served as pathologist on the staff of St. Joseph's Hospital for five years. He was the first president of the Paterson Tuberculosis League and was a medical director of Riverlawn Sanitorium in Paterson. For many years he specialized in industrial surgery.

THE BULLETIN BOARD

NEW JERSEY DOCTORS WORK WITH THE PUBLIC

The influence of The Medical Society of New Jersey now reaches into every aspect of public life involving health, medical care, or welfare. The laws of the state require several state agencies to consult The Medical Society of New Jersey in formulating or altering standards of education or medical performance. The Medical Society is specifically represented on a number of official boards and councils charged with various public functions.

Practically every state-wide voluntary agency engaged in health or medical care programs has officially designated an appropriate committee of the Medical Society as its own official medical advisory committee. Hence, in effect, The Medical Society of New Jersey directs and controls the expenditure of practically every dollar spent within the state by voluntary health organizations for medical or health purposes.

The Medical Society of New Jersey recognized early the importance of the voluntary agencies in public health work and has long offered its complete cooperation. The Society, in fact, has a standing offer to give its professional advice and guidance to any group working in the field of health, provided this group bases its program on recognized scientific standards and agrees to maintain ethical relationships with the physicians and the public.

In 1945, The Medical Society of New Jersey took the initiative in forming the New Jersey Health Congress, comprising representatives of more than twenty state-wide governmental, consumer and professional groups. The Congress, which meets five times a year, serves as a forum for discussion of problems relating to the quality, quantity and distribution of professional services, including medical, dental, pharmaceutical, nursing and hospital functions. It is anticipated that this Congress may soon become the nucleus of a state-wide health council, embracing representatives of many other organizations, and its scope of interest will then be broadened to take in all matters of health or medical interest. The Congress now includes representatives of labor, industry and farm groups, as well as all the governmental departments having any medical functions, and, of course, the professions.

Some years ago, The Medical Society of New Jersey initiated and continues to sponsor the development of two corporations, each having special functions with relation to the distribution of medical care. One, the Medical-Surgical Plan of New Jersey, operates one of the oldest and soundest voluntary medical care insurance programs in the United States, currently serving nearly 250,000 subscribers. The other agency is the Medical Service Administration of New Jersey. This corporation studies the needs of indigent and medically indigent patients and evolves plans to meet their needs, with or without the aid of tax funds. For more than five years it has operated such a plan in the city of Newark. This plan guarantees to the clients of city relief agencies, as well as to the medically indigent, class A medical care. Services are given by the physician of the patient's choice and under the same conditions as apply for self-supporting private patients in the city.

The public leadership of The Medical Society of New Jersey was dramatically manifest in November 1948, when, in cooperation with its twenty-one county medical societies and the state and local health departments, it sponsored a state-wide "Public Health Week", formally proclaimed as such by Governor Driscoll. For five days during "Public Health Week", the medical societies and health departments, with the cooperation of other professional, lay and voluntary agencies interested in public health, staged an observance in practically every county in the state. In twelve metropolitan centers, full-scale public health shows were put on, comprising exhibits and demonstrations, afternoon or evening forums or lecture programs, health motion picture shows, newspaper features, radio programs, and public school poster and essay contests. This represented perhaps the most comprehensive project in health education ever attempted by a state medical society. It is expected to become an annual event in New Jersey.

James E. Bryan
Executive Officer.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

NEW BIRTH, DEATH REPORT FORMS

New forms for the reporting of births, stillbirths and deaths will be put into use throughout the state on January 1, 1949.

Several months ago state health officers, state registrars, federal agencies and representatives of public health, medicine, social welfare, demography and insurance as well as full time city and county health officers and state and county medical societies were requested to submit suggestions for the improvement of these forms. The suggestions were reviewed and the Council on Vital Records and Statistics developed standard birth, stillbirth and death certificates for use by the various states.

The new certificates are different in format. They eliminate certain items, provide more complete statistical information and make statistical analysis of records and permanent filing an easier and less costly operation. The forms have been designed so that they may be used on the ordinary typewriter. This will eliminate the arduous completion of certificates in longhand and errors which result from mis-reading of handwriting.

THE NEW DEATH CERTIFICATE

Important changes have been made in the medical certification of the cause or causes of death section of the death certificate. The latest revision of the International List of Causes of Death will go into effect January 1, 1949, coinciding with the first use of the new standard certificates. The new International List of Causes of Death will be available from the National Office of Vital Statistics, (Washington 25, D. C.) by January 1.

The Interim Commission of the World Health Organization proposed that an International Statistical Classification of Diseases, Injuries, and Causes of Death be considered as a basis for the statistical classification of causes of illness as well as causes of death. The major criticism of the old medical certification form was that there was no indication as to what is expected of the physician. The item "Immediate Cause of Death" was ambiguous and subject to varying interpretations; the lines with "Due to" actually misleading since they implied causal relationship of the antecedent causes. The items "Other conditions" and "Duration" also lacked specificity.

The lack of specific instructions on the face of the old certificate was reflected in the returns on causes of death. From 20 to 30 per cent of the old medical certifications have been defective in that the cause sequence was improbable, the underlying cause was omitted, or that there was confusion between the direct causes and the contributing causes.

The revision of the medical certification form follows the recommendations of the Expert Committee on the Preparation of the Sixth Decennial Revision of the International List. Basically, the form is the same as the old medical certification, but the phraseology has been modified and instructions have been included. The item "Immediate Cause of Death" has been reworded to read "Disease or condition directly leading to death" with a note to specify that mode of dying is not to be reported. The term "Due to" has been qualified by "or as a consequence of" to indicate that the conditions reported are not necessarily related etiologically but that they occurred in a particular time sequence.

BIRTH CERTIFICATE

The birth and stillbirth certificates have been altered in format but the various items remain substantially unchanged.

Local registrars of vital statistics will receive bulk supplies of the new death, birth and stillbirth forms this month. Sample copies of the new forms will be mailed by the State Department of Health to every physician in New Jersey. Office supplies of the new forms will be provided for all practicing physicians by the registrar of vital statistics of the municipality in which the physician has his office.

All hospitals in the state will be supplied with the 1949 forms in quantity before the first of the year. Supplies of the death and stillbirth forms will also be sent to funeral directors in New Jersey.

With the help of all persons concerned, the changeover in record forms can be made without difficulty and New Jersey will have the full benefit of the improved standard forms.

COUNTY SOCIETY REPORTS

BURLINGTON COUNTY

T. Bruce Dickson, M.D., Reporter

The week of November 8, was Public Health Week in the State of New Jersey. In accordance with this *The Burlington County Medical Society* put on a Public Health Exhibit in the gymnasium of the High School in Burlington. Under the direction of Dr. Arthur B. Peacock, chairman of The County Public Health Committee, there were thirteen different exhibits, namely: first aid, tuberculosis, diabetes mellitus, heart, cancer, dental, orthopedics, venereal disease, conservation of vision, maternal welfare and child health, Red Cross, Burlington County Hospital and Zurbrugg Memorial Hospital. Each one of these was manned by a member of the County Society. Every afternoon and evening there were moving pictures depicting some phase of Public Health work. Each evening there was a public forum which discussed a topic of general interest to the laity. It was thought by those who attended the exhibits and the physicians that Public Health Week in Burlington County was a definite success.

Following the forum on Thursday, November 11, the society held a short business meeting. Dr. William Bray, chairman of the Public Relations Committee of the State Society, commented that the exhibits and the number of people who attended this display indicated that the program was a great achievement. Dr. J. Howard Hornberger, president of the State Society, expressed his appreciation for the time and effort that the members expended on Public Health Week.

CAMDEN COUNTY

Harold K. Eynon, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held at 9:00 p. m., November 2, 1948, at the Camden County General Hospital, Tuberculosis Division, Blackwood.

The speaker of the evening was HENRY A. BRODKIN, M.D., Chief Medical Consultant, New Jersey State Rehabilitation Commission. His subject was "Rehabilitation of the Tubercular Patient". Dr. Brodkin reviewed the present day status of tuberculosis treatment in its three phases, namely:

1. Case findings
2. Treatment
3. Rehabilitation

Discussion was opened by Dr. Martin Collier, Medical Director of the Camden County Tuberculosis Hospital.

GLOUCESTER COUNTY

L. K. Collins, M.D., Reporter

DR. FRED FAUX, president, served as toastmaster at the Annual Ladies' Night and Social Session of the *Gloucester County Medical Society*. This gala affair was held at the Woodbury Country Club on the evening of October 21. The delicious dinner was enjoyed by 104 members and guests, among the latter being Dr. J. Howard Hornberger, president of the State Medical Society. Dr. Hornberger favored us with a few remarks, requesting that he be invited back for a regular meeting when he would have more time to express himself.

The principal address of the evening was given by KARL SCHOLZ, Ph.D., professor of Economics at the University of Pennsylvania, whose topic was "A Look Behind the Iron Curtain". Dr. Scholz had been in Europe seven times, in Russia three times, and had just returned from Czechoslovakia, whence he obtained most of the material for his interesting though controversial discussion.

At the conclusion of the dinner meeting, dancing was enjoyed.

MERCER COUNTY

A. D. Hutchinson, M.D., Reporter

The *Mercer County Medical Society* held a very interesting meeting on November 10, PRESIDENT CORIO *presiding*, at which time DR. CRANSTON W. HOLMAN, associate professor of Surgery, Cornell Medical College, addressed the members on "Surgical Treatment of Peptic Ulcer".

JAMES E. BRYAN, executive officer of The Medical Society of New Jersey, discussed the various activities of the State Society, and appealed to the members for whole-hearted cooperation, emphasizing the necessity for a 100 per cent delegation at the annual meeting to be held in April, 1949.

There were nine applicants elected to Associate membership, and thirteen to Active membership in the Society.

Dr. Kustrup in reporting for the Public Health Week Committee, commended the efforts of Dr. Majeski in publicizing the program, and praised the work accomplished by Drs. Herman Cohen, A. D. Summers, Lloyd, Moriconi, Byer, William Moore and Sullivan in arranging many open meetings and providing films and radio talks in the hospitals of the city. The N. J. Pharmaceutical Association and the Mercer County Dental Society cooperated to the fullest extent in aiding the educational program. Approximately 45 doctors have taken part in the radio addresses, and at least 60 physicians have been assigned to address schools, Parent-Teacher Associations, service clubs and many other groups.

Owing to the Clinical Conference conflicting with the regular meeting date of the Society—the Annual Meeting, a change was made, advancing the Annual Meeting for the election of officers for the year, to November 10.

The following were elected, to assume office subsequent to the State meeting in April 1949:

President, WILLIAM C. IVINS, M.D.; *President-Elect*, HAROLD S. MAGEE, M.D.; *Secretary-Reporter*, A. D. HUTCHINSON, M.D.; *Treasurer*, P. B. REISINGER, M.D.; *Executive Committee*, DRS. R. E. MILLER, J. D. PREECE, M. YALE BYER; *Finance Committee*, D. C. LYNCH, M.D.; *Board of Censors*, J. N. ZIMSKIND, M.D.; *State Nominating Committee*, D. L. HAGGERTY, M.D.; *Alternate*, F. E. PROCTOR, M.D.; *Delegates*, DRS. ACKLEY, BELLIS, COTTONE, SWERN,

Stein, Blaugrund, Schildkraut and Wikoff; *Alternates*, Drs. Blackwell, Chianese, Fessler, Max Friedman, M. H. Friedman, Pessel, Bonnet and Purcell.

The revised Constitution and By-Laws will be thoroughly discussed at the December 15 meeting.

MIDDLESEX COUNTY

Anthony J. Pellicane, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on October 20, 1948, at 9:00 p. m., at the Roosevelt Hospital, Metuchen.

The meeting was called to order by Dr. F. M. Clarke, vice-president, in the absence of Dr. Edward F. Klein, president.

The minutes of the special June 9th meeting were read and approved without change.

Dr. Charles H. Calvin reported for the Committee on Medical Ethics. On recommendation of this committee, the following members were approved for regular membership from Associate membership: Drs. Emanuel Kant and Bori Berkow of Perth Amboy; Martha F. Leonard and Gabriel Pickar of Highland Park; Mates Morgenstern, Bernard D. Stollman and Clark F. Miller of New Brunswick.

The following members were approved for a two-year period of Associate membership: Drs. Marie Idelcowitz, South River; Otto Walker, Carteret; Leon J. Dwulet, Jamesburg; Edward J. Novak, Woodbridge and George M. Benko, Perth Amboy.

Dr. Calvert R. Toy, chairman of the Medical Practice Committee, presented a brief summary of report on Middlesex County Welfare patients. Patients are to have free choice of physician, with the fee schedule being as follows: office visit, $2.00; home visit, $3.00; home visit at a distance of 5 miles or more, $4.00. Service rendered multiple, eligible persons during same visit to be full fee for one person plus one-half fee for each additional eligible person, with a ceiling of $6.00 for any one visit. Bills shall be submitted to the County Welfare Board before the 10th of the following month. The chairman stated that a summary of this Welfare Agreement would be sent to each member of the Society, and that action on same would be taken at the November meeting.

Dr. F. M. Clarke reported that post-graduate courses have been started in New Brunswick and Perth Amboy, with an excellent attendance at each place.

Dr. H. P. Fine, chairman, Public Health Committee reported that preparations were being made for a "Public Health Week".

A motion was moved and carried that the Middlesex County Medical Society donate $500 to defer expenses in connection with this exhibit.

Dr. Edward Brezinski, chairman of the Program Committee reported that the Annual Dinner in December will be held at Mario's in Metuchen.

Action on the remaining provisions still to be approved in the revised Principles of Medical Ethics was deferred until the next meeting. In the interim, these articles will be distributed to the general membership for their prior consideration.

The 1948 Nominating Committee was announced as follows: Drs. N. B. Cole, Perth Amboy, Chairman; E. A. Hauber, Sayreville, and F. S. Taber, New Brunswick.

Dr. Kohut, treasurer, reported that the annual 1948 dues will be increased to $42.00. The State Medical Society 1949 assessment for active members is $24.00; the county society assessment, $18.00. A motion was moved and carried to increase the dues to $42.00 for active members for 1949.

A motion was made, seconded and approved to have a suitable memorial written on behalf of Dr. George W. Fithian, who died August 9, 1948. Dr. Naulty was appointed to prepare this resolution.

The speaker of the evening, Dr. Henry Dolger, adjunct physician for Metabolic Diseases. The Mt. Sinai Hospital, New York City, spoke on "Recent Advances in the Treatment of Diabetes Mellitus". His lecture was presented in an interesting manner and was profusely illustrated with many clinical highlights.

Dr. Elmer L. Sevringhaus, Nutley, N. J., director of Endocrinology and Nutrition, Medical Center, Jersey City, led the discussion that followed the lecture. He presented many interesting suggestions on diabetic control.

There being no other business, the meeting was adjourned.

Refreshments were served in the Hospital dining room.

SOMERSET COUNTY

H. E. Cook, M.D., Reporter

The *Somerset County Medical Society* in joint sponsorship with the Somerset County Chapter of the American Cancer Society of the New Jersey Division, Inc., held one of the largest and most interesting conferences of its long history on October 8, 1948. The *Conference on Clinical Frontier Problems in Cancer* was held at the Far Hills Inn, near Pluckemin.

The conference was widely attended and among the more than 300 physicians and guests present, were many distinguished physicians from other countries.

The following is a brief synopsis of the program:

Moderator: Dr. Earl T. Engle, professor of Anatomy, College of Physicians and Surgeons.

First Session—9:30 a. m.

Leukemia, Dr. Joseph F. Ross, associate professor of medicine, Boston University School of Medicine.

The Pathologist's Responsibility in the Diagnosis and Treatment of Cancer, Dr. Lauren V. Ackerman, associate professor of Surgical Pathology, Washington University School of Medicine.

Cancer of the Gastro-Intestinal Tract, Dr. George T. Pack, attending surgeon, Memorial Hospital for Cancer and Allied Diseases; clinical professor of Surgery, New York College of Medicine.

Luncheon—12:30 p. m.

Second Session—2:00 p. m.

How Can the Family Physician Make Earlier Diagnosis of Pelvic Malignancy in Women?, Dr. Lewis C. Scheffey, professor of Obstetrics and

Gynecology; head of Department and director of Division of Gynecology, Jefferson Medical College and Hospital.

Earlier Detections of Urologic Neoplasms, DR. ROBERT S. HOTCHKISS, director, Department of Urology, New York University School of Medicine; associate professor of Surgery (Urology), Cornell University Medical College.

Malignant Tumors of the Breast, DR. FRANK E. ADAIR, attending surgeon and executive officer, Memorial Hospital Treatment Cancer and Allied Diseases; associate professor, Cornell University Medical College.

Cocktails and dinner—6:00 p. m.

Third Session—7:00 p. m.

Futures in Cancer Research, DR. JOSEPH C. AUB, director, Cancer Commission of Harvard University, Medical Laboratories of the Collis P. Huntington Memorial Hospital.

The *Somerset County Medical Society* held its opening meeting of the 1948-49 season on October 14, 1948, at the Far Hills Inn, Pluckemin. DR. A. F. MANGELSDORF presided. This was our annual dinner meeting and the Society was out in good attendance with their ladies for a very enjoyable evening.

The social portion of the program was preceded by a brief business session in which the following were elected to membership: DR. H. ABRAMSON and DR. A. GERWANTER of Somerville; DR. J. WILSON and DR. I. BLECHER of Bound Brook; and DR. L. VAN DYKE of Bernardsville.

The social portion of the program was opened by a professional ventriloquist who singled out one of our fine members to act as his dummy. The audience was engulfed in gales of laughter during this and similar antics by the very clever entertainer. Dancing followed the planned portion of the entertainment and a very pleasant evening was enjoyed by all.

SUSSEX COUNTY

R. A. Weinstein, M.D., Reporter

The regular meeting of the *Sussex County Medical Society* was held at the Sussex Inn, Sussex, on September 24. The meeting was called to order by the president, DR. EDDY, at 10:15 p. m.

The minutes of the May meeting were read and corrected as follows: "That the Cancer Committee felt that radium was not needed as permanent equipment."

Dr. Spurgeon reported that the Cancer Committee had planned to conduct a public forum for the purpose of educating the public in the problems of cancer control.

A report of the Public Health Week Committee was made by Dr. McCall in which he stated that arrangements were made for speakers at various service clubs, schools, etc. He further suggested that the public forum on cancer control be held in conjunction with Public Health Week.

It was therefore decided that the regular county meeting be held on November 12, at the Sparta Inn, preceding the public forum on cancer control to be held at the Sparta Auditorium at 8:00 p. m. The post graduate education committee arranged for a prominent speaker for the scientific meeting who would also take part later at the public forum.

A report of the Welfare Committee was made by Dr. Kirschner who stated that there were several changes made in the fee schedule for welfare patients; but that the contract otherwise would remain the same.

A motion was made by Dr. Piampiano that a protest be made to the Trustees of the State Medical Society against the regulation in the State contract, which in effect, limits choice of physician by a patient. After considerable discussion, the motion was not carried.

A request from certain lay individuals to organize a spastic paraplegic clinic was introduced by Drs. Eddy and Weinstein. The latter reported that the Newton Kiwanis Club had allotted a certain sum to equip such a clinic. Dr. Eddy then appointed Drs. Bergman and Weinstein as a committee to determine the practicability of this clinic before final approval by the Society.

A report was made by Drs. Eddy and Piampiano of a lay individual in the county, who, by offering a cancer cure, was virtually practicing medicine without a license. After considerable discussion, Dr. Eddy undertook to report this matter to the State Board, so that they could take action.

Following a collation, the meeting was adjourned at 11:40 p. m.

NEW JERSEY RHEUMATISM ASSOCIATION

Cyril M. Canright, M.D., Reporter

The *New Jersey Rheumatism Association* held its fall business meeting, followed by a scientific meeting on November 5, 1948, at the Academy of Medicine in Newark.

PRESIDENT GRAY conducted a brief business session in which expansion of arthritis clinics throughout the state and their incorporation in the nationwide effort now beginning—to supply better service to the many sufferers with arthritis and its allied diseases, was discussed. Mr. Weeks of the American Rheumatism Association presented the broader national effort being made by that Association. He told of the effort to develop this organization throughout the United States, to raise funds, establish clinical research, study medical biology and public health problems. An ambitious program to raise $2,000,000 for this organization began on November 15. Mr. Bob Winter will direct this effort and Bob Hope, radio and screen star, will be co-chairman.

DR. OTTO STEINBROCKER, president of the New York City Rheumatism Association, gave a paper on "Reflex Dystrophy", accompanied by lantern slides. He answered questions following the presentation of his paper, and graciously explained various questions about his method of treatment and possibilities of success with it.

The next meeting of the Association is scheduled for April, 1949.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Robert B. Walker, President

The Woman's Auxiliary extends to the members of The Medical Society of New Jersey and their families friendly Yule-tide greetings.

Remembering the purpose for which we are organized, we have striven to serve you by assisting, in dispensing health information to the public through our Rural Health Program. We are most grateful for the cooperation and support which we have received from our parent-body, the Medical Society.

It is our aim to have all counties organized as auxiliaries to their Medical Societies, so that we may have the full support of a state-wide organization; thus affording to us the opportunity of influencing other organizations to be of service in the promotion of public health.

At this Christmas Season the prayers of the Auxiliary are offered for the bereaved, the ill, and for those in distress in physicians' families. May the blessings of the Season bring to you and yours, peace and the joy of true happiness.

PUBLIC HEALTH WEEK ACTIVITIES

The County Auxiliaries demonstrated the purpose of their existence by the splendid efforts put forth in the successful completion of the Public Health Week programs.

Camden, Essex and Somerset counties held one day meetings and each county had six speakers on its panel. Camden used four exhibits and had nine organizations represented in the two hundred people attending the meeting. Essex was hostess to more than 600 representatives of 129 organizations. The sixteen exhibits included one of the Woman's Auxiliary to The Essex County Medical Society which depicted the activities of the doctor's wife. Posters placed in doctors' offices and hospitals and the daily newspaper articles helped in furthering the publicity. Somerset had fourteen organizations represented among the 2000 citizens who attended their meeting. Thirty-two exhibits were displayed. Daily newscast announcements, a forum on the air and posters were used for publicity.

Bergen county had a three-day health program which was viewed by about 5000 people. High school students participated in an essay contest. A poster contest conducted in the grammar school brought 100 entries. Seventeen exhibit booths and a series of motion pictures were presented. An x-ray bus, in which 814 people had chest x-rays taken, was an added feature.

The Burlington county Public Health Show featured thirteen splendid exhibits, visited by several thousand students. Open forums and cancer films were presented each evening. Auxiliary members publicized the program by distributing literature throughout the county and urged the attendance of school children. Photographs of the exhibits, in the newspaper, added to the public interest.

Mercer county auxiliary members worked with the medical society in contacting organizations throughout the county. They were instrumental in placing an article in the Chamber of Commerce Magazine concerning Public Health Week. Daily newspaper items and the 45 doctors, who participated in the radio programs, did much to publicize the Health Week program.

Middlesex county auxiliary members served as guides for the Public Health Week Program and conducted an information center. Motion pictures and physician speakers were featured nightly.

Passaic county Health Week Program was attended by more than 1600 persons from 21 organizations. There were 35 exhibit booths many of which demonstrated medical examinations and tests. One of the six radio programs presented during the health week was devoted to the Auxiliary. Feature stories, newspaper releases, photographs and editorials helped to make the public aware of this important program.

COUNTY AUXILIARY MEETINGS

The Woman's Auxiliary to the Atlantic County Medical Society held its second monthly meeting on November 12. An excellent review of the book "An Affair of State" was given by Mr. Ben Barkan, of the Atlantic City High School English Department. Mrs. David B. Allman reported on the Fifth Annual Conference of presidents and presidents-elect, which was held in Chicago. Mrs. Clarence B. Whims conducted the meeting in the absence of the president.

The Woman's Auxiliary to the Essex County Medical Society opened the season with a luncheon meeting on October 25. Mrs. Manfred Kraemer, president, welcomed the members and their guests. Dr. George Blackburne, president of the Essex County Medical Society extended greetings and an invitation to the Auxiliary members to attend the meetings of the Medical Society. Dr. Joseph I. Echikson, president-elect of the Essex County Medical Society spoke on the chronically ill in Essex County. Mrs. Robert B. Walker, State President of the Auxiliary gave an informative talk. Mrs. Norman Nathanson, president-elect of the State Auxiliary, extended greetings. Essex Auxiliary was happy to have the president of Hudson County Auxiliary and her guests attend the meeting. A fashion show followed the meeting.

The Annual Legislative Meeting of the Woman's Auxiliary to the Hudson County Medical Society was held November 1. Mrs. William Gleeson, president, presided. Mrs. Andrew Ruoff, Legislative Chairman, introduced the guest speakers: Dr. C. B. Blaisdell, State Chairman of Public Health and Mrs. Oswald R. Carlander, State Chairman of Legislation of the Woman's Auxiliary to the State Medical Society.

The first fall meeting of the Woman's Auxiliary to the Mercer County Medical Society was held on September 20. Dr. William V. Carroll, Advisor to the Auxiliary, was the guest speaker. Mrs. Robert B. Walker, president of the State Auxiliary extended greetings.

BOOK REVIEWS

Correlative Neuro-Anatomy. By J. J. McDonald, J. G. Chusid and Jack Lange. ed. 4. University Publishers, Palo Alto, California 1948. $3.00. (Pp. 156)

No physician can be expected to carry in his head the intricate anatomy of the nervous system. In seeking to explain a bizarre symptom, to localize the nerve or root responsible for an area of sensory change or to determine the level of a lesion, the doctor needs a book containing charts. It is awkward to pull a large volume out of a shelf and to page furiously through it looking for a chart while the patient waits.

This book well fills the need for such a *vade mecum*. The general practitioner will find here a compact manual of practical neurology, and even the experienced specialist will be grateful for having all the material condensed neatly in one little paper-bound volume. Included are numerous diagrams which show the distribution and components of the cranial, spinal and autonomic nerves, and the essentials of brain and cord localization.

The first part deals with the peripheral nerves. Each major nerve is well illustrated and systematically described. The autonomics are concisely discussed including the physiology and pharmacology of the system.

The section on neurodiagnosis includes a discussion of anatomy, physiology and localization in the brain and spinal cord. The subjects of motion, sensation, reflexes, trophic changes, electric examination, intracranial pneumography and cerebrospinal fluid are outlined. A discussion of electroencephalography with representative electroencephalograms has been added in this new edition.

The third section of the book, which deals with disorders of the central nervous system, has been completely rewritten and enlarged.

The appendix gives a list of neurologic signs and syndromes, a brief discussion of muscular dystrophies and atrophies and an outline of the neurologic examination.

M. W. Bergman, M.D.

Planning Your Exhibit. Janet Lane and Beatrice Tolleris. National Publicity Council, 130 E. 22 St., New York. 1948. Illustrated. $1.00.

The medical society or hospital which has to plan an exhibit without professional public relations help, often does an obviously amateurish and ineffective job. Here is a lively how-to-do-it book which analyzes display technics, emphasizes clarity, lists suitable display materials, and reviews the essential but often forgotten mechanical factors, such as space, fire regulations, electric outlets and audience participation devices. Written in a breezy, readable style it offers first-aid to the society or hospital official who has been given the thankless job of planning an exhibit and who needs help quickly.

V. Huberman, M.D.

Endocrine Therapy in General Practice. By E. L. Sevringhaus, M.D., 6th Ed. Pp. 264. The Year Book Publishers, Chicago. 1948. $4.00.

The continued succes of "Endocrine Therapy in General Practice" is shown by the need for seven printings and six editions in ten years. It covers the diagnosis and treatment of most endocrine disorders, together with the treatment of such endocrine emergencies as diabetic coma, insulin shock and crisis in Addison's disease.

References for further reading, which appear at

the end of each chapter, are extremely useful and eliminate the consideration of much unnecessary and controversial material.

No major changes in the basic contents have been made in this edition, but a careful revision has clarified modern concepts of endocrinology and its relationship to allied disorders. The author's succint and ethical listing of endocrine preparations serves a useful purpose. This book is an excellent compendium for the general practitioner because of its brevity, simplicity and clarity.

Stella K. Saslow, M.D.

Contemporary Religious Jurisprudence. By I. H. Rubenstein. Waldain Press, Box 97, Chicago (90), Illinois. Pp. 120. No index. $2.50.

In this ambiguously entitled text, the reader will find an interesting treatise on the civil and criminal aspects of faith healing, pacifism, and fortune telling. The chapter on faith healing reviews the legal status of faith healers with reference to the medical practice acts of the several states, and analyzes such problems as the culpability of failure to seek medical care because of the parent's faith in some spiritual method of healing, the validity of religious freedom as a defense, the factor of commercialism in promoting unscientific methods of healing, and the like. The chapters on pacifism and fortune telling, while not squarely within the range of the physician, are, none the less, worth reading for their own intrinsic interest.

Although there is no alphabetical index, the table of contents represents a topical analysis of the book which makes it easy to find each subject. All statements made by the author are supported by documentation or citation, and the citations cover statutes from states in the four corners of the nation. The treatise, as a whole, reflects high grade scholarship. Although cognizant of the importance of preserving religious freedom, the author is firm in his belief that "the law must remain as a bulwark against those who would use religion as a sword to gain fanatical ends". The book is thus a brief for a thesis which most physicians would warmly endorse, and it provides a useful factual framework for any doctor involved in a debate, public or private, with faith healers or other cultists.

William S. Schram, M.D.

Progress in Neurology and Psychiatry. Edited by E. A. Spiegel. Grune and Stratton, New York, 1948. $10.00. 661 pp.

No specialist can hope to read and absorb all the articles published in his field; mechanical problems of office space and filing technic make it awkward to keep and use freely the current periodical literature. It is necessary, therefore, for the specialist to have a ready reference compend of the literature and the various year books, digests, and annual reviews are offered for that purpose.

The usual annual review simply abstracts articles and arranges the abstracts in some logical order. The current volume, however, represents one of the newer types of scientific anthology. Here the editor of each section writes a critical review of the field, rather than a simple summary of published articles.

The book is divided into 37 chapters each covering one phase of the specialty. Thus there are sections on brain tumors, mental hygiene, epilepsy, neuropathology, rehabilitation, etc. A few of the editors use their chapters as platforms for delivery of their own ideas rather than as stages for reviewing the literature. For example, there is a 16-page section on "criminal psychopathology" Five pages are devoted to reviewing the literature and eleven pages to expounding the author's own interesting but highly unworkable ideas on the subject! This, however, is the only chapter which shows so grotesque a disproportion between an objective review of progress and an exposition of personal opinion.

In this book are references to 2737 recent articles on neuropsychiatry, most of them published during 1947. The neuropsychiatric practitioner can thus turn to it to find the latest thought on anything in his specialty. Whether he wants material for a talk on child psychiatry or a prescription for the treatment of migraine, he will find it here. It is a compact kaleidoscope of the march of neuropsychiatry during the past two years.

Henry A. Davidson, M.D.

Physical Medicine in General Practice. By William Bierman, M.D., with a chapter on Medical Rehabilitation, by Dr. Sidney Licht. 2nd ed. 686 pp. New York, Paul B. Hoeber, Inc., 1947. $8.00.

This book places its main emphasis on technics of physical therapy and physiologic rationale. Historical material and discussions of the physics of the agents under discussion have been largely omitted, keeping the general tone of the book more practical than discursive. Illustrations are plentiful and of real utility.

All branches of the field are covered, including every mode of producing clinically useful heat, hydrotherapy, spa and climatotherapy, therapeutic exercise, manipulation, and occupational therapy. Medical rehabilitation of the convalescent is well discussed in terms of achieving optimal readjustment to an independent and satisfying existence. Throughout the book, attention is called to the special dangers of the physical agents against which the practitioner must guard himself and his patient.

The author has made his own the cause of Sister Kenny. A lengthy section of the chapter on neurologic diseases is devoted to her concepts and methods. From the uncritical way in which the material is presented, one must presume that the author agrees wholeheartedly with Sister Kenny and feels that her pronouncements are entirely valid. This unquestioning acceptance of Sister Kenny *in toto* is not general among top orthopedic authorities.

As a whole, the book is an adequate guide to physical medicine for the general practitioner. It will give him adequate data on what to expect of the therapeutic methods available in institutions.

Bernard Chromow, M.D.

THE JOURNAL

OF

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The Official List of Members and Fellows will be found as the Supplement to the April issue. The Transactions of the Annual Meeting appear as a supplement to the August issue.

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Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXI **December, 1948** **No. 12**

THE CONTROL of pulmonary tuberculosis depends on the early diagnosis, isolation and treatment of the active cases. Nothing has been added to our knowledge in recent years to change this fundamental fact. In its early stage, tuberculosis has no characteristic symptoms and no significant physical findings. X-ray examination is necessary for its detection.

THE DIAGNOSIS OF PULMONARY TUBERCULOSIS

It is important to place pulmonary tuberculosis near the top of the list of diagnostic possibilities in cases giving a history of nervousness, digestive disturbance, loss of weight, productive cough, and pulmonary hemorrhage. When the disease is accompanied by such symptoms it is usually easy to find tubercle bacilli in the sputum and chest films show extensive infiltration and cavitation. Such patients still make up a large majority of those admitted for sanatorium treatment. Extensive surgical procedures are frequently required for permanent arrest of the infection. Treatment periods run to two and three years with significant mortality rates. The patient with arrested advanced disease is a handicapped individual whose rehabilitation offers further problems. Reactivation of the infection in later years occurs with disappointing frequency. Everyone around such a patient has been exposed to tubercle bacilli for weeks or months. The disease perpetuates itself in this way.

The early case offers a pleasant contrast to the above picture. There has been little opportunity for spread of infection and arrest of the disease can be achieved much more frequently with shorter periods of treatment. When collapse therapy is necessary the simpler procedures are usually sufficient. The residual handicap is slight and recurrence of active disease in later life is exceptional.

It is therefore of basic importance in the diagnosis of pulmonary tuberculosis to find it in the early stages. Failure in early diagnosis has often occurred because physicians had a low index of suspicion of its presence. It is not unusual for the first search for tuberculosis to be made at the suggestion, or even at the insistence, of the patient. At other times tuberculosis may have an acute onset and advanced disease is discovered soon after the first symptoms.

However, the majority of cases of pulmonary tuberculosis develop slowly. Symptoms are absent or so slight that the individuals seldom go to doctors and their examination must be brought about by education and community endeavor. When patients seek medical advice the diagnosis of pulmonary tuberculosis becomes a direct professional responsibility which can be met only by considering the possibility of tuberculosis in every patient. The private physician has been a leader in tuberculosis case finding in the past. Routine methods will be required to maintain this position in the face of the decreasing morbidity of the disease.

Misplaced confidence in physical examination is another common cause for delay in the discovery of pulmonary tuberculosis. Too much stress cannot be placed on the limitations of physical diagnosis. In almost every case of early or latent pulmonary disease, percussion and auscultation are so inadequate as to be practically a waste of time. Doctors continue to be surprised at the extent of pulmonary lesions as shown by X-ray examination. Most minimal and many advanced cases of active pulmonary tuberculosis would easily be missed in even a careful physical examination.

There are two methods of screening out the few cases without depending on symptoms and physical findings. These are the tuberculin test and the X-ray examination of the chest. One or the other should be used routinely. The chest film appeals to most doctors because it also reveals cardiac and other pulmonary abnormalities at once. These advantages have led to the present campaign for X-ray examination of all hospital admissions. In

office practice the tuberculin test is very helpful as it takes little time. A positive reaction indicates previous exposure to tuberculosis and is an indication for proceeding with X-ray examination. [Another screening method for physicians in general practice is the use of the fluoroscope. If the fluoroscope shows suspicious findings, the patient can then be tuberculin tested and a chest X-ray made—Author's note.]

The patients with suspicious X-ray shadows are found by these screening methods. Evaluation of the film findings in each instance requires a complete history and careful clinical study including a tuberculin test. For practical purposes a negative tuberculin reaction rules out active tuberculosis.

It is necessary not only to determine the presence of tuberculosis, but also the degree of activity of the lesion. Recovery of tubercle bacilli from pulmonary secretions gives absolute proof of active disease. Culture or guinea pig inoculation of one or more fasting gastric specimens may be required in the absence of a productive cough. Serial chest films are always more helpful than any single examination. An unstable tuberculous lesion, even though retrogressive, must be considered active.

The search for pulmonary tuberculosis has been greatly stimulated by the practical application of small film photofluorography. This trend will probably continue with community and industrial surveys and with the study of hospital admissions. All physicians will be having these chest X-ray problems brought to their attention. Tuberculosis will be outnumbered by other abnormalities of the lungs, mediastinum and cardiovascular system. More frequent opportunities will be available for early diagnosis of malignant tumors, especially bronchogenic carcinoma. Here, everything depends on prompt referral for surgical exploration and resection.

The Diagnosis of Pulmonary Tuberculosis, George H. Vernon, M.D., Illinois Medical Journal, December, 1947.

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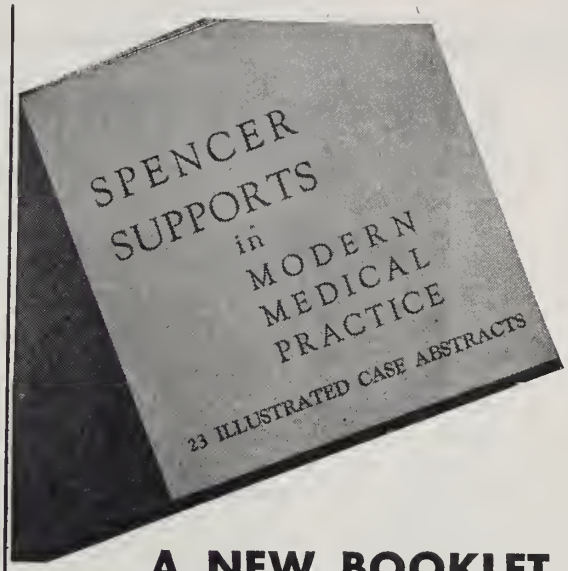
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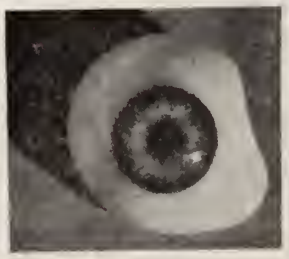
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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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The Medical Society of New Jersey

ITS STRUCTURE AND FUNCTION

and

Official List--March 1, 1948

of

FELLOWS AND MEMBERS

Supplement to The Journal of The Medical Society of New Jersey, April, 1948

The Medical Society of New Jersey

ITS STRUCTURE AND FUNCTION
and
OFFICIAL LIST—MARCH 1, 1948
of
FELLOWS AND MEMBERS

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Supplement to The Journal of The Medical Society of New Jersey, April, 1948

THE MEDICAL SOCIETY OF NEW JERSEY

Founded, July 23, 1766 — Chartered March 14, 1864

A federation of twenty-one independent component county societies which, by delegation, govern the state society. Composed of FELLOWS, the ex-presidents of the Society; OFFICERS, a President, a President-Elect, two Vice-Presidents, a Secretary, a Treasurer, members of the Board of Trustees, the COUNCILORS; DELEGATES chosen by and from the component societies; MEMBERS, of component societies in good standing; HONORARY and EMERITUS members.

HOUSE OF DELEGATES
(Legislative Body)

Composed of FELLOWS; OFFICERS; DELEGATES elected by component societies - one for each fifteen members or major fraction thereof; no component society less than three; term three years.

BOARD OF TRUSTEES
(Ad-interim Body)

Composed of 6 Officers, Immediate Past President, 11 elected members at least 2 from each of 5 judicial districts; term 3 years.

JUDICIAL COUNCIL
(Judicial Body)

1 councilor elected from each of 5 districts; term 3 years, President, ex-officio

MEDICAL SERVICE ADMINISTRATION / MEDICAL-SURGICAL PLAN

Seperate corporations sponsored by The Medical Society of New Jersey; nominations for Boards of Trustees must be approved by the society

EXECUTIVE

OFFICERS - President, President-Elect, 2 Vice-Presidents, Secretary, Treasurer; CHAIRMAN and SECRETARY of Board of Trustees; EXECUTIVE STAFF appointed by Trustees - Executive Officer, Executive Assistant, Medical Director - Distribution of Medical Care, secretarial force.

MEDICAL DIRECTOR

Appointed by The Medical Society of New Jersey

ADMINISTRATIVE

Special Committees - authorized by House of Delegates or Trustees

- Military Service - 4 veteran physicians, 3 civilian physicians appointed by Trustees, term 1 year
- Study of Medical Care - 7 members appointed by President, term 1 year
- Veterans Liaison - 1 from each of 5 judicial districts appointed by Trustees; term 1 year

Finance and Budget - 3 elected by House, 3 elected by Trustees; term 6 years, Treasurer ex-officio

Publication - 3 elected, term 3 years; President and Secretary, ex-officio

- Editorial Staff - Editor and Assistant Editor; appointed by Trustees.

Woman's Auxiliary Advisory - 5 appointed by President; term 3 years

Welfare - 35 including President and Secretary, at least 1 from each component society, candidates for such may be suggested to President by component societies Appointed by President, term 1 year. Work divided into 4 sub-committees of 5 each appointed by President, Chairman of each appointed by Welfare Chairman with President's approval; term 1 year. Special advisory committees, 5 each, formed an approval of Trustees; appointed by President, term 1 year.

REPRESENTATIVE

Delegates and Alternates to the American Medical Association - 5 of each elected; term 2 years

Delegates and Alternates to Other State Medical Societies - 1 of each elected, term 1 year

Official representatives of the society nominated by the Board of Trustees or the President, with the approval of the Board, to the following official and non-official agencies upon invitation;

- Crippled Children Commission Medical Advisory Committee
- Commissioner of Labor's Advisory Committee on Workmen's Compensation
- New Jersey Health and Sanitary Association
- New Jersey Health Congress
- New Jersey Hospital Council, Inc.
- Hospital Service Plan of New Jersey
- Medical Service Administration of New Jersey
- State Board of Medical Examiners
- Medical-Surgical Plan of New Jersey
- Middle Atlantic States Conference
- State Board of Examiners of Nurses (consultant)
- Joint Committee on Professional Relationships
- Professional Relationships Committee of Physicians and Dentists
- Hospital Licensing Board Advisory Committee
- Medical Advisory Committee to Rutgers Univ.

SCIENTIFIC

Medical Defense and Insurance - 5 appointed by President, term 3 years

Scientific Work - 1 elected from each of 5 judicial districts, term 5 years, 2 appointed by President, term 2 years

Honorary Membership - 3 Fellows appointed by President; term 3 years

Post Graduate Education - 5 appointed by President, term 3 years

Annual Meeting - 5 Appointed by President, term 3 years

- Fall Clinical Conference - Annual scientific session sponsored jointly by the Society and a designated component society
- Scientific Exhibits - Chairman, member of main committee, with 2 appointed by President; term 1 year
- Scientific Program - Chairman, member of main committee, with 2 appointed by President; term 1 year
- Scientific Sections - authorized by Trustees; Chairmen and Secretaries elected by individual groups
  - Anesthesiology
  - Chest Diseases
  - Clinical Pathology
  - Diseases of Metabolism
  - Eye, Ear, Nose and Throat
  - Gastro-Enterology and Proctology
  - Medicine
  - Neuropsychiatry
  - Obstetrics and Gynecology
  - Orthopedics
  - Pediatrics
  - Radiology
  - Surgery
  - Venereal Disease Control

Public Health
- Adult Disease Control
- Cancer Control
- Cardio-Vascular Diseases
- Child Health
- Conservation of Vision and Hearing
- Crippled Children
- Maternal Welfare
- Mental Hygiene
- Nutrition
- School Health
- Tropical Diseases
- Tuberculosis
- Venereal Disease Control

Medical Practice
- Anesthesiology
- Contract Practice
- Hospital Relationships
- Industrial Health and Hygiene
- Medical Care of Indigent
- Laboratory Medicine
- Nursing and Nursing Education
- Pharmaceutical Problems
- Physical Medicine
- Radiology
- Workmens Compensation

Legislation
- Executive Secretary appointed by Trustees
- Keymen - 1 in each county society

Public Relations

Note: On request of Committee, President may appoint additional members; such appointments to cease at close of next annual meeting

THE MEDICAL SOCIETY OF NEW JERSEY
ITS STRUCTURE AND FUNCTION

Royal A. Schaaf, M.D., President

In the course of my travels during the past two years through all parts of our state, I have held many casual conversations with fellow members of our Society who were interested in knowing about certain phases of our organization and activities. It occurred to me that when there was so much interest readily manifested, it might serve a useful purpose to present a brief outline of our structure and function for the information of all of our members.

EMBRYOLOGY

The Medical Society of New Jersey was founded July 23, 1766, component County Societies being first chartered in 1816. In 1825, the State Legislature delegated to the Society the authority to confer the degree of Doctor of Medicine. The Society became an original constituent of the American Medical Association when the latter body was created in 1847. Since The Medical Society of New Jersey was older than the State Government, its charter did not originally derive from the state. Accordingly, the Senate and General Assembly of the State of New Jersey enacted Chapter 157 of the Laws of 1864 chartering The Medical Society of New Jersey, its charter being still in force.

ANATOMY

The Society is composed of fellows, officers, delegates and members of component societies in good standing. As at present constituted, The Medical Society of New Jersey is a federation of twenty-one component units, one for each county in the state. The fountain head of authority resides in the House of Delegates by which the Society is governed. This body is composed of the officers, the trustees and the delegates, one delegate being elected for each fifteen members (or major fraction thereof) of its respective component society with no county society having fewer than three delegates. The House of Delegates traditionally meets annually but special meetings may be convoked at any time to deal with emergency questions of major importance. In the interim between annual meetings, full power and authority is vested in the Board of Trustees who are empowered to make final decisions on all but a few special matters as provided in the Constitution and By-Laws. The Board of Trustees is composed of the six elected officers of the Society (President, President-Elect, 1st and 2nd Vice-Presidents, Secretary and Treasurer), eleven elected Trustees, not less than two from each councilor district (the odd Trustee may be elected from any of the five districts), and the immediate past President who serves for one year following the conclusion of his term of office. The Judicial Council is composed of one councilor elected from each of the five councilor districts. They constitute the Board of Censors of the Society. All questions of an ethical nature are referred to the Judicial Council by the House of Delegates or the Board of Trustees without discussion. The Judicial Council decides all questions of ethics and discipline and also certain legal points. Decisions of the Judicial Council are binding unless or until reversed or modified by the House of Delegates.

PHYSIOLOGY

The officers may be said to be the executive arm of the Society. It is their duty to carry out the instructions and policies of the House of Delegates and the Board of Trustees. Only limited authority reposes in the presidency. The President presides at meetings of the House of Delegates but not at meetings of the Board of Trustees, which elects its own chairman. The function of the President is to represent the Society in all contacts with the public and to coordinate the actions of the committees and the administrative staff. He must at all times have in mind the many and varied concurrent activities and must participate in the work of all committees when his services are needed. The President-Elect and the two Vice-Presidents function in that order in the absence or incapacity of the next higher officer. The duties of the Secretary and Treasurer are those usually befalling upon such officers. The administrative staff includes the Executive Officer, the Executive Assistant, The Director of Distribution of Medical Care, the Secretary of the Legislative Committee, the Editor and Assistant Editor of The Journal, and the Publication Committee.

The purpose and structure of the Society are well described in the following extracts from its constitution and by-laws:

PURPOSE

To federate and organize the medical profession of the state of New Jersey;

To unite with similar organizations of other states to compose the American Medical Association;

To advance medical science, elevate professional standards, safe-guard the material interest of and promote friendly relations among members of the medical profession;

To educate the public in prevention of disease and the preservation of health; and, in general,

To render this profession most capable of serving humanity.

MEMBERSHIP

Every reputable and legally registered physician shall be deemed eligible to membership.

HOUSE OF DELEGATES

Shall be the *legislative* body, and shall hear appeals from the decisions of the Judicial Council.

The Nominating Committee shall be composed of one elected delegate from each component society; Chairman shall be the Junior Past-President of the society or the member elected by the Fellows.

Shall report to the House of Delegates in the form of a ticket containing nominations for each of the offices to be filled.

Reference Committees: At each Annual Meeting the President shall appoint, from members of the House, reference committees of five members each, to serve during the session. To these committees may be referred any reports, resolutions, measures, or propositions which have been presented to the House. The committees shall meet forthwith, discuss the questions referred, and hear debate thereon by any interested member of the society; and shall submit its recommendations to the House for action.

THE BOARD OF TRUSTEES

The Board of Trustees is the *executive* body. It exercises general supervision over the affairs of the society, with authority to act for the society between annual meetings. and

To make recommendations to the House of Delegates;

To advise in the deliberation of the several standing committees;

To supervise the work of the Publication Committee and, when necessary, to appoint an editor and such other assistants as the needs of the society may require;

To determine all salaries;

To pass upon all recommendations for incurring expense, over and above that provided in the budget;

To order all necessary expenditures;

To refer and otherwise dispose of all business, properly arranged for its disposition;

To require and hold the official bond of the Treasurer and to annually audit his accounts;

To fill vacancies in all offices and elected standing committees until the next annual meeting;

To lease, sell, or otherwise convey or dispose of any or all property of the society, both personal and real, and to executive therefor, good and sufficient lease, deed, or other conveyance.

In accordance with the statutes of this state, as vacancies occur in the State Board of Medical Examiners by reason of the expiration of term, or otherwise, of members of said Board representing this society, the Trustees shall nominate for each appointment three members of this society, the names of such nominees shall then be transmitted by the President of this society to the Governor of the state.

JUDICIAL COUNCIL

The Councilors collectively, shall constitute a Board of Censors of this society.

MEDICAL SERVICE ADMINISTRATION OF OF NEW JERSEY
MEDICAL-SURGICAL PLAN OF NEW JERSEY

These are separate corporations sponsored by the State Society. Nominations for these boards must be approved by the society.

THE PRESIDENT OF THE MEDICAL SOCIETY

The president presides at all meetings of this society and of the House of Delegates; appoints all committees not otherwise provided for; is an ex-officio member of all standing committees except Nominating Committee; and performs such other duties as custom and parliamentary usage may require. The President-Elect and Vice-Presidents assist President in discharge of his duties.

THE SECRETARY

The Secretary has custody of Constitution and By-Laws of society and of records of society and House of Delegates, under the direction of the Trustees; he attends all meetings of society and of House of Delegates, and keeps a record of their proceedings; he gives notice of all general and special meetings of the House of Delegates or of the society, to members of the House or society; he notifies Honorary Members of their election.

He requires and receives from secretaries of county societies a list of their representatives in House of Delegates and the Nominating Committee, and publishes such lists at such times and in such manner as the House of Delegates may direct.

He has sole custody of the Official Seal of the society and shall affix same to such correspondence or instruments as the By-Laws may require or the Trustees or President may direct. He conducts such formal official correspondence in the corporate name of the society as the Trustees or the President may direct, and performs such other functions as are specified in By-Laws.

TREASURER

The Treasurer gives bond, at expense of society, in such amount as may be required by Trustees; he receives and preserves all funds due society; he does not pay any money out of

treasury except on resolution of Trustees, or upon voucher of officer or committee responsible for expenditure, countersigned by Chairman of Finance Committee, and as provided in annual budget.

He collects assessments from each component society; and performs such other duties as may be assigned to him.

SPECIAL COMMITTEES

These may be created by the House of Delegates or by the Board of Trustees. They are appointed by the President, or the Chairman of the Board of Trustees, and their specific functions and term of life shall be clearly defined.

STANDING COMMITTEES

Finance and Budget Committee prepares a budget to be submitted to the House of Delegates; controls the expenditure of money by officers and committees and is authorized to require from any officer or committee any necessary fiscal information.

The Publication Committee publishes and distributes THE JOURNAL; has authority to curtail, abstract, or to return to the author, such material submitted for publication as seems to it unsuitable for publication, with a statement of the reasons therefor.

The Scientific Work Committee collects information, through the county reporters or otherwise, of members interested in prosecuting scientific studies or research, privately or in hospitals, schools, health departments, or other agencies in the state; supports and encourages such work, as means and opportunity may be available, and in general promotes interest in original scientific work among the members of the society; facilitates contacts and exchanges between workers in related fields in different parts of the state; and expedites the presentation of such work and its result to the society, either at its meetings, through the committees in charge, or in THE JOURNAL, through the Publication Committee.

The Woman's Auxiliary Advisory Committee approves the programs of the Auxiliary and assists in coordinating Auxiliary activities with State Society's programs.

The Medical Defense and Insurance Committee is responsible for all matters pertaining to alleged malpractice of members and all other types of insurance, such as health, accident, life and automobile, which may be recommended to the members; has responsibility for the protection of the members and the contracts and relations with the insurance companies, brokers, and agents with whom it is dealing; maintains contact with the Judicial Council and refers complaints of an ethical nature to that body. This Committee shall not enter into contracts without approval of Trustees or House of Delegates.

Honorary Membership Committee inquires into the standing and qualifications of all nominees for honorary membership.

The Post-Graduate Education Committee provides a continuous program of post-graduate education for the members within the resources of the society. It advises upon, correlates and promotes all the post-graduate activities of the special committees in cooperation with educational institutions.

The Annual Meeting Committee has complete charge of all arrangements, plans and programs for the annual meeting and all details pertaining thereto. This committee provides suitable accommodations for the Annual Meeting, for the general and section sessions, house of delegates, trustees, committees, woman's auxiliary and exhibits.

The Scientific Program Committee arranges for papers, addresses and orations for the annual meeting; sees that the speakers are properly received and that scientific papers are delivered as scheduled. The classification and number of scientific sections is determined by this committee.

The Committee on Scientific Exhibits prepares and arranges for all details in connection with scientific exhibits of the annual meeting.

Each Scientific Section elects its own chairman and secretary who in turn are responsible to the chairman of the scientific program.

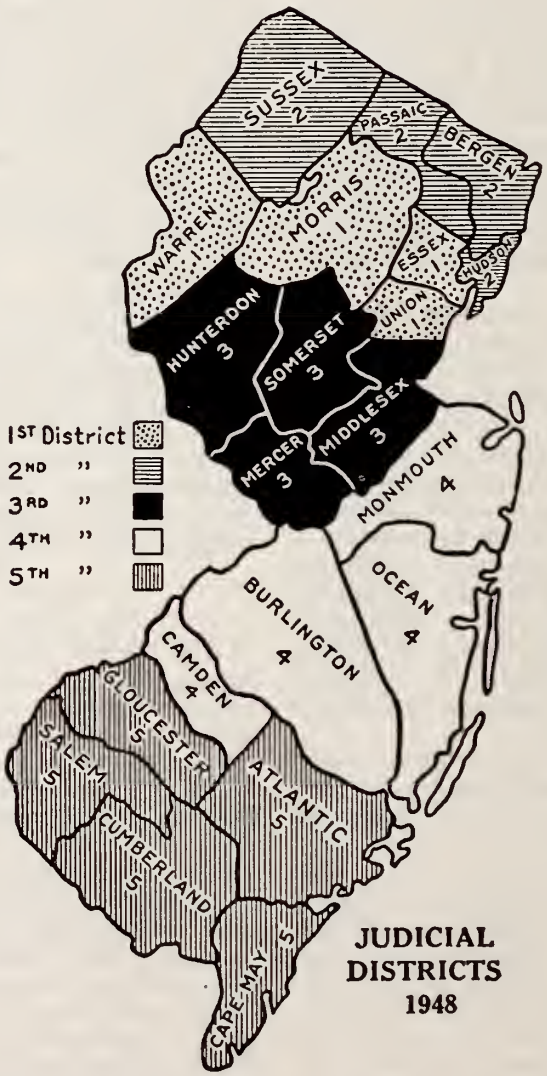
The Fall Clinical Conference is an interim scientific session under the auspices of the State Society sponsored by a county society designated by the Board of Trustees.

WELFARE COMMITTEE

The Welfare Committee is a unique feature of The Medical Society of New Jersey, representing a sort of town meeting of the county societies integrated at the state level. It is a large committee, numbering about sixty members, so that every corner of the state is represented on its membership. It has supervision over the Society's interest in legislative matters (both national and state) over public health, public relations and medical practice. It provides a channel between the county society and the state society—a channel which is open in both directions. The views, questions and recommendations of the county society can be brought to the attention of the general membership through the county society's welfare committeeman; conversely, the committeeman can bring back to the county society an intimate behind-the-scenes account of the activities of the state society. The Welfare

Committee is a sounding board for all points of view on society problems; it is a forum for presentation of recommendations; it is a mechanism for screening suggestions on their way to the Board of Trustees. The Welfare Committee furnishes the officers and trustees with a body of experienced and seasoned advisers reflecting varied points of view from varied parts of the state.

Structurally the committee functions through four subcommittees. Two of the subcommittees in turn are assisted by advisory committees. The subcommittees deal with legislation, public relations, public health and medical practice. Affiliated with the last two are advisory committees on every major specialty of medicine and surgery and on a number of special topics such as hospitals, contract practice, workmen's compensation, industrial health, pharmaceutical problems, etc.



OFFICIAL LIST OF MEMBERS

OF

THE MEDICAL SOCIETY OF NEW JERSEY

FOR THE YEAR 1948

FELLOWS

"THE FELLOWS ARE THE EX-PRESIDENTS OF THE SOCIETY." (Constitution, Article IV. Section 2-a)

Year of Election

1. 1766—Robert McKean, Perth Amboy, 1732-1767
2. 1767—William Burnet, Newark, 1730-1791
3. 1768—John Cochran, New Brunswick, 1730-1807
   1769—John Cochran, No. 3, reëlected
4. 1770—Nathaniel Scudder, Freehold, 1733-1781
5. 1771—Isaac Smith, Trenton, 1740-1807
6. 1772—James Newell, Freehold, 1725-1791
7. 1773—Absalom Bainbridge, Lawrenceville, 1742-1807
8. 1774—Thomas Wiggins, Princeton, 1731-1801
9. 1775—Hezekiah Stites, Cranbury, 1726-1790

No formal meetings 1776-1780 on account of the War of the Revolution.

1781—James Newell, No. 6, reëlected

10. 1782—John Beatty, Trenton, 1749-1826
11. 1783—Thomas Barber, Matawan, 1730-1807
12. 1784—Lawrence Vander Veer, Roycefield, 1740-1815
13. 1785—Moses Bloomfield, Woodbridge, 1729-1791
    1786—William Burnet, No. 2, reëlected
14. 1787—Jonathan Elmer, Bridgeton, 1745-1817
15. 1788—James Stratton, Swedesboro, 1755-1812
16. 1789—Moses Scott, New Brunswick, 1738-1821
17. 1790—John Griffith, Rahway, 1736-1805
18. 1791—Lewis Dunham, New Brunswick, 1754-1821
19. 1792—Isaac Harris, Middlesex County, 1741-1808

No elections held in 1793 and 1794 because quorum not present.

20. 1795—Elisha Newell, Allentown, 1755-1799

No formal meetings 1796-1806 owing to an attempt to establish a rival society in Eastern New Jersey.

21. 1807—Jonathan F. Morris, Somerville, 1760-1810
22. 1808—Peter I. Stryker, Somerville, 1766-1859
23. 1809—Lewis Morgan, Rahway, 1757-1821
24. 1810—Lewis Condict, Morristown, 1773-1862
25. 1811—Charles Smith, New Brunswick, 1768-1848
26. 1812—Matthias H. Williamson, Elizabeth
    1813—Matthias H. Williamson, continued for second year
27. 1814—Samuel Forman, Freehold, 1764-1845
28. 1815—John Van Cleve, Princeton, 1778-1826
    1816—Lewis Dunham, No. 18, reëlected
    1817—Peter I. Stryker, No. 22, reëlected
    1818—John Van Cleve, No. 28, reëlected
    1819—Lewis Condict, No. 24, reëlected
29. 1820—James Lee, Newark
30. 1821—William G. Reynolds, Manalapan

Year of Election

31. 1822—Augustus R. Taylor, Somerville, 1782-1840
32. 1823—William B. Ewing, Greenwich, 1776-1866
    1824—Peter I. Stryker, reëlected. Also served 1808 and 1817.
33. 1825—Gilbert S. Woodhull, Manalapan, 1794-1830
34. 1826—William D. McKissack, Millstone, 1781-1853
35. 1827—Isaac Pierson, Orange, 1770-1833
36. 1828—Jephtha B. Munn, Chatham, 1780-1863
37. 1829—John W. Craig, Somerset County, 1795-1871
    1830—Augustus R. Taylor, No. 31, reëlected
38. 1831—Thomas Yarrow, Sharptown, 1778-1841
39. 1832—E. FitzRandolph Smith, New Brunswick, 1786-1865
40. 1833—William Forman, Monmouth County, 1796-1848
41. 1834—Samuel Hayes, Newark, 1776-1839
42. 1835—Abraham P. Hagerman, Somerset County
43. 1836—Henry Vander Veer, Somerville, 1792-1874
44. 1837—Lyndon A. Smith, Newark, 1795-1865
45. 1838—Benjamin H. Stratton, Mt. Holly, 1804-1875
46. 1839—Jabez G. Goble, Newark, 1799-1859
47. 1840—Thomas P. Stewart, Hackettstown, 1798-1846
48. 1841—Ferdinand S. Schenck, Six Mile Run, 1790-1860
49. 1842—Zachariah Read, Mt. Holly, 1808-1879
50. 1843—Abraham Skillman, Bound Brook, 1796-1862
51. 1844—George R. Chetwood, Elizabeth, 1802-1885
52. 1845—Robert S. Smith, Bound Brook, 1800-1874
53. 1846—Charles Hannah, Deerfield, 1782-1857
54. 1847—Jacob T. B. Skillman, Woodbridge, 1794-1864
55. 1848—Samuel Hayes Pennington, Newark, 1806-1900
56. 1849—Joseph Fithian, Woodbury, 1795-1881
57. 1850—Elias J. Marsh, Paterson, 1803-1850
58. 1851—John H. Phillips, Pennington, 1814-1878
59. 1852—Othneil H. Taylor, Camden, 1803-1869
60. 1853—Samuel Lilly, Lambertville, 1815-1880
61. 1854—Alfred B. Dayton, Middletown Point, 1812-1870
62. 1855—James B. Coleman, Trenton, 1806-1877
63. 1856—Richard M. Cooper, Camden, 1816-1874
64. 1857—Thomas Ryerson, Newton, 1821-1887
65. 1858—Isaac Pierson Coleman, Pemberton, 1804-1869
66. 1859—John R. Sickler, Mantua, 1800-1886
67. 1860—William Elmer, Bridgeton, 1814-1889

Year of Election

68. 1861—John Blane, Perryville, 1802-1885
69. 1862—John Woolverton, Trenton, 1825-1888
70. 1863—Theodore R. Varick, Jersey City, 1825-1887
71. 1864—Ezra M. Hunt, Metuchen, 1830-1894
72. 1865—Abraham Coles, Newark, 1813-1891
73. 1866—Benjamin R. Bateman, Bridgeton, 1807-1883
74. 1867—John C. Johnson, Blairstown, 1828-1907
75. 1868—Thomas J. Corson, Trenton, 1828-1879
76. 1869—William Pierson, Orange, 1796-1882
77. 1870—Thomas F. Cullen, Camden, 1822-1877
78. 1871—Charles Hasbrouck, Hackensack, 1818-1877
79. 1872—Franklin Gauntt, Burlington, 1823-1900
80. 1873—Thomas J. Thomason, Perrineville, 1833-1880
81. 1874—George H. Larison, Lambertville, 1831-1892
82. 1875—William O'Gorman, Newark, 1824-1887
83. 1876—John V. Schenck, Camden, 1825-1882
84. 1877—Henry R. Baldwin, New Brunswick, 1829-1902
85. 1878—John S. Cook, Hackettstown, 1827-1900
86. 1879—Alexander W. Rogers, Paterson, 1814-1905
87. 1880—Alexander N. Dougherty, Newark, 1822-1882
88. 1881—Lewis W. Oakley, Elizabeth, 1828-1888
89. 1882—John W. Snowden, Blackwood, 1823-1888
90. 1883—Stephen Wickes, Orange, 1813-1889
91. 1884—Phanett C. Barker, Morristown, 1835-1903
92. 1885—Joseph Parrish, Burlington, 1818-1891
93. 1886—Charles J. Kipp, Newark, 1838-1911
94. 1887—John W. Ward, Trenton, 1840-1916
95. 1888—H. Genet Taylor, Camden, 1837-1916
96. 1889—Beriah A. Watson, Jersey City, 1836-1892
97. 1890—James S. Green, Elizabeth, 1829-1892
98. 1891—Elias J. Marsh, Paterson, 1835-1908
99. 1892—George T. Welch, Passaic, 1845-1924
100. 1893—John G. Ryerson, Boonton, 1834-1916
101. 1894—Obadiah H. Sproul, Flemington, 1844-1925
102. 1895—William Elmer, Trenton, 1840-1908
103. 1896—Thomas J. Smith, Bridgeton, 1841-1932
104. 1897—David C. English, New Brunswick, 1842-1924
105. 1898—Claudius R. P. Fisher, Bound Brook, 1859-1927
106. 1899—Luther M. Halsey, Williamstown, 1858-1921
107. 1900—William Pierson, Jr., Orange, 1830-1900
108. 1901—John D. McGill, Jersey City, 1846-1912
109. 1902—Edward L. B. Godfrey, Camden, 1850-1913
110. 1903—Henry Mitchell, Asbury Park, 1845-1919
111. 1904—Walter B. Johnson, Paterson, 1852-1922
112. 1905—Henry W. Elmer, Bridgeton, 1847-1907
113. 1906—Alexander Marcy, Jr., Riverton, 1860-1934
114. 1907—Edward J. Ill, Newark, 1854-1942
115. 1908—David St. John, Hackensack, 1850-1917

Year of Election

116. 1909—Benjamin A. Waddington, Salem, 1842-1917
117. 1910—Thomas H. MacKenzie, Trenton, 1847-1920
118. 1911—David Strock, Camden, 1850-1927
119. 1912—Norton L. Wilson, Elizabeth, 1861-1931
120. 1913—Enoch Hollingshead, Pemberton, 1843-1924
121. 1914—Frank D. Gray, Jersey City, 1857-1916
122. 1915—William J. Chandler, South Orange, 1842-1927
123. 1916—Philip Marvel, Atlantic City, 1856-1938
124. 1917—William G. Schauffler, Lakewood, 1862-1933
125. 1918—Thomas W. Harvey, Orange, 1853-1938
126. 1919—Gordon K. Dickinson, Jersey City, 1855-1930
127. 1920—Philander A. Harris, Paterson, 1852-1924
128. 1921—Henry B. Costill, Trenton, 1860-1935
129. 1922—James Hunter, Jr., Westville, 1866-1931
130. 1923—Wells P. Eagleton, Newark, 1865-1946.
131. 1924—Archibald Mercer, Newark, 1849-1931. Resigned.
1924—**LUCIUS F. DONOHOE**, Acting President
132. 1925—**LUCIUS F. DONOHOE**, Bayonne, born 1868
133. 1926—James S. Green, Jr., Elizabeth, 1864-1936
134. 1927—Walt P. Conaway, Atlantic City, 1873-1945
135. 1928—Ephraim R. Mulford, Burlington 1880-1939
136. 1929—Andrew F. McBride, Paterson, 1869-1946
137. 1930—**GEORGE N. J. SOMMER**, Trenton, born 1874
138. 1931—John F. Hagerty, Newark, 1869-1937
139. 1932—A. Haines Lippincott, Camden, 1867-1937
140. 1933—**FREDERIC J. QUIGLEY**, Union City, born 1883
141. 1934—**LANCELOT ELY**, Somerville, born 1875
142. 1935—**MARCUS W. NEWCOMB**, Browns Mills, born 1880
143. 1936—Francis R. Haussling, Newark, 1875-1941 —resigned
144. 1936—**SPENCER T. SNEDECOR**, Hackensack, born 1900
145. 1937—**WILLIAM G. HERRMAN**, Asbury Park, born 1890
146. 1938—William J. Carrington, Atlantic City, 1884-1947
147. 1939—**E. ZEH HAWKES**, Newark, born 1865
148. 1940—**WATSON B. MORRIS**, Springfield, born 1878
149. 1941—**THOMAS K. LEWIS**, Camden, born 1887
150. 1942—Elias J. Marsh, Paterson, 1875-1943
151. 1943—**RALPH K. HOLLINSHED**, Westville, born 1884
152. 1944—**JOSEPH F. LONDRIGAN**, Hoboken, born 1884
153. 1945—**SAMUEL ALEXANDER**, Park Ridge, born 1888
154. 1946—Frank G. Scammell, Trenton, 1877-1947.
155. 1947—**ROYAL A. SCHAAF**, Newark, born 1892.

The names of living Fellows are in bold face type.

HONORARY MEMBERS

Year of Election

1. 1930—Joseph E. Raycroft, Princeton
2. 1939—Nathan V. Van Etten, New York
3. 1939—Haven Emerson, New York

Year of Election

4. 1945—Lucius F. Donohoe, Bayonne
5. 1947—Mr. John S. Thompson, Glen Ridge

MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising

THE MEDICAL SOCIETY OF NEW JERSEY

ON MARCH 1, 1948

ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets second Friday evening monthly, except in June, July and August. Annual Meeting in May.

ACTIVE MEMBERS

Allar, Ellis H., 115 St. Charles pl., Atlantic City
Allman, David B., 104 St. Charles pl., Atlantic City
Andrews, Clarence L., 1616 Pacific av., Atlantic City
Axilrod, Maurice H., 2620 Pacific av., Atlantic City
Baldwin, Charles H., 2829 Atlantic av., Atlantic City
Bartlett, Clara K., 4301 Atlantic av., Atlantic City
Bassett, Norman H., 1616 Pacific av., Atlantic City
Bayer, Harold J., 1616 Pacific av., Atlantic City
Beir, Ily R., 3900 Atlantic av., Atlantic City
Bew, Richard C., 1217 Pacific av., Atlantic City
Bradley, Robert A., 1616 Pacific av., Atlantic City
Brown, J. Carlisle, 101 S. Indiana av., Atlantic City
Charlton, C. Coulter, 1616 Pacific av., Atlantic City
Clark, S. Worth, 152 S. No. Carolina av., AtlanticC'y
Cleary, Joseph P., Minotola
Collins, John F., 1208 Columbia av., Pleasantville
Corson, Filbert R., 101 S. Indiana av., Atlantic City
Crane, Bernard, 306 Pacific av., Atlantic City
Cutler, Milton, 554 Bellevue av., Hammonton
Dalton, S. Eugene, 101 S. Surrey av., Ventnor
Davidson, Harold S., 117 S. Illinois av., Atlantic City
deHellebranth, Roland T., 104 S. Fr'nkf't av.,Ventn'r
Dein, Harry, 1616 Pacific av., Atlantic City
Dierwechter, Reuben, 12 N. Providence av., Atl. City
DiNicolantonio, Vincent J., 3121 Atlantic av., Atl. C'y
Dintenfass, Arthur, 1616 Pacific av., Atlantic City
Diskan, Samuel M., 1616 Pacific av., Atlantic City
Durham, Robert B., 110 S. North Carolina av., Atl. C.
Durham, Royal E., 100 S. New Haven av., Ventnor
Dyer, Edward H., 102 S. Victoria av., Ventnor
Eckert, Walter L., 11532 Dilling st., N. Hollyw'd,Cal.
Ellenbogen, Leonard S., 5407 Atlantic av., Ventnor
Elliott, Frazier J., 10 N. Second st., Hammonton
Erber, Leonard B., 1902 Pacific av., Atlantic City
Ernst, Philip A., 16 E. Main st., Mays Landing
Esposito, Antonio L., 31 12th st., Hammonton
Ewens, Arthur E., 3600 Pacific av., Atlantic City
Feinstein, Louis, 410 Pacific av., Atlantic City
Fowler, Richard M., Jr., 112 N. Indiana av., Atl.City
Fox, Wm. W., 101 S. Indiana av., Atlantic City
Frank, Myrtile, 227 Philadelphia av., Egg Harbor
Frank, Perry, 227 Philadelphia av., Egg Harbor
Goldstein, Samuel, 34 E. Main st., Mays Landing
Gordon, Benjamin L., 6917 Atlantic av., Ventnor
Gordon, Maurice B., 6917 Atlantic av., Ventnor
Gorson, Samuel F., 2005 Pacific av., Atlantic City
Gottlieb, Morris, 1616 Pacific av., Atlantic City
Green, Martin, 2643 Pacific av., Atlantic City
Grier, Robt. M., 50 E. Washington av., Pleasantville
Gross, Max, 7401 Atlantic av., Margate City
Gruhler, Jean A., 101 S. Indiana av., Atlantic City
Guion, Edward, 1219 S. Main st., Pleasantville
Halpern, Samuel, 7405 Ventnor av., Margate City
Hamburger, Werner, 1616 Pacific av., Atlantic City
Harley, Halvor L., 101 S. Indiana av., Atlantic City
Harley, Robison D., 101 S. Indiana av., Atlantic City
Harris, William O., 32 N. New Jersey av., Atl. City
Hersohn, William W., 20 S. Elberon av., Atl. City
Hess, L. Elmore, 19 E. Bolton av., Absecon
Hoffman, Harry S., 3302 Pacific av., Atlantic City
Holmes, H. David, 15 N. Indiana av., Atlantic City
Holoman, M. Browne, 1 N. Haverford av., Margate
Hudson, Howard S., 824 Wesley av., Ocean City
Hughes, James W., Jr., 1903 Pacific av., Atlantic C'y
Hyman, Charles, 2807 Pacific av., Atlantic City
Infield, Gerald L., 1319 Shore rd., Northfield
Jacobson, J. Joseph, 1616 Pacific av., Atlantic City
Johnson, V. Earl, 101 S. Indiana av., Atlantic City
Kahn, Leo, 32 States av., Atlantic City
Kaighn, Chas. B., 101 S. Indiana av., Atlantic City
Kaman, Samuel L., 1616 Pacific av., Atlantic City
Kline, Herman, 2643 Pacific av., Atlantic City
Konzelmann, Frank W., 304 S. Shore rd., Absecon
Krechmer, Abraham, 400 Pacific av., Atlantic City
Lawther, Boyd M., 1401 Shore rd., Northfield
Leonard, Isaac E., 2842 Atlantic av., Atlantic City
Leonard, Isaac E., Jr., 2842 Atlantic av., AtlanticC'y
Lippman, Nathan L., 504 Pacific av., Atlantic City
Lucas, Stanley L., 44 N. Kentucky av., Atlantic City
Magill, Marcus, 4116 Ventnor av., Atlantic City
Major, Morton M., 4212 Ventnor av., Atlantic City
Marshall, H. Donald, 707 N. Indiana av., AtlanticC'y
Marvel, Peter H., 2216 Shore rd., Northfield
Marvel, Philip, Jr., 101 S. Indiana av., Atlantic City
Mason, James H., 1616 Pacific av., Atlantic City
McCracken, Josiah C., Jr., 16 S. Suffolk av., Ventnor
McGahn, Joseph, 18 S. Stenton pl., Atlantic City
McGeehan, Stanley M., 6505 Atlantic av., Ventnor
Merendino, Anthony G., 2720 Pacific av., AtlanticC'y
MeVay, James C. F., 2907 Pacific av., Atlantic City
Milano, Cesare A., 1 S. Brighton av., Atlantic City
Mishler, Jay E., 1616 Pacific av., Atlantic City
Molitch, Matthew, 705 Pacific av., Atlantic City
Murray, Clifford K., 5901 Ventnor av., Ventnor
Nickman, E. Harrison, 1616 Pacific av., Atlantic C'y
Paul, Abraham, 4901 Atlantic av., Ventnor
Pennington, John, 101 S. Indiana av., Atlantic City
Perez, John F., 3403 Pacific av., Atlantic City
Petinga, Thomas J., 114 S. Illinois av., Atlantic City
Pilkington, Albert, 117 S. Virginia av., Atlantic City
Poland, Geo. A., 206 E. Verona av., Pleasantville
Powell, Robert J., 410 N. Ohio av., Atlantic City
Quinn, Norman J., 3303 Pacific av., Atlantic City
Read, Hilton S., 5407 Atlantic av., Ventnor
Reinhard, Louis, 2627 Pacific av., Atlantic City
Reyner, Daniel C., 2703 Pacific av., Atlantic City
Rieck, Allan, 507 S. Shore rd., Pleasantville
Rise, Wilson S., 1616 Pacific av., Atlantic City

Rodi, Louis M., 412 Bellevue av., Hammonton
Roop, William O., 101 S. Indiana av., Atlantic City
Rosenberg, Louis, 1616 Pacific av., Atlantic City
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City
Rubba, Russell R., 21 Horton st., Hammonton
Salasin, Samuel L., 511 Pacific av., Atlantic City
Saseen, Charles A., 60 S. Delancey pl., Atlantic City
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
Schwarzkopf, George C., 2901 Pacific av., AtlanticC'y
Shavelson, Irving C., 1616 Pacific av., Atlantic City
Shenfeld, Isaac, 4806 Atlantic av., Ventnor
Shivers, Chas. H. deT., 121 S. Illinois av.. Atl. City
Shuster, Samuel A., 405 Pacific av., Atlantic City
Silvers, Homer I., 16 S. Suffolk av., Ventnor
Sinderbrand, Robert E., 344 Phila. av., Egg Harbor
Sinkinson, Chas. D., Jr., 1616 Pacific av., AtlanticC'y
Stamps, G. Ruffin, 1616 Pacific av., Atlantic City
Stewart, Sloan G., 43 S. North Carolina av., Atl. City
Stewart, Walter B., 8 N. Tallahassee av., Atl. City
Subin, Harry, 2 S. Somerset av., Ventnor
Surran, Carl A., 1616 Pacific av., Atlantic City
Targan, Nathan, Grammercy Ct. Apts., Atlantic City
Timberlake, Baxter H., 5414 Ventnor av., Ventnor
Uzzell, Edward F., 2703 Pacific av., Atlantic City
Vandenberg, Werner, 7 S. La Clede pl., Atlantic City
Walker, Levi M., 5407 Atlantic av., Ventnor
Weeks Belford A., 534 S. Shore rd., Absecon
Weiner, Samuel E., 904 Pacific av., Atlantic City
Weintrob, Joseph R., 1616 Pacific av., Atlantic City
Westney, F. Rolfe, 1920 Pacific av., Atlantic City
Whims, Clarence B., 5407 Atlantic av., Ventnor
White, R. Rostin, 644 Shore rd., Somers Point
Williams, Raymond A., 7207 Atlantic av., Ventnor
Wilson, Lawrence A., 114 N. Shore rd., Absecon
Winn, Samuel L., 1616 Pacific av., Atlantic City

ASSOCIATE MEMBERS

Axilrod, Herbert D., 2620 Pacific av., Atlantic City
Bew, David F., 7500 Ventnor av., Margate
Brown, Francis S., 2216 Shore rd., Northfield
Erskine, Frederick A., Vet'ns Hosp., Oteen, N.Car.
Mallis, Leonard I., 6 N. Austin av., Atlantic City
Naame, John M., 19 N. Dorset av., Ventnor
Ruby, Victor M., 174 States av., Atlantic City
Salasin, Robert G., Army
Woolbert, Edwin, 15 W. Washington av., Pleasantv'e

COURTESY MEMBERS

Barab, Barney B., D.D.S., Atlantic City
Berger, A. E., Atlantic City
Jonas, Charles S., D.D.S., Atlantic City
Mally, Manuel J., D.D.S., Atlantic City
Martucci, P. C., Atlantic City
Starkes, Col. Carlton C., Linwood
Steigerwald, Clarence S., Ventnor

HONORARY MEMBERS

Altman, Hon. Joseph, Atlantic City
Brown, Hon. W. Elmer, Atlantic City
Farley, Hon. Frank S., Atlantic City
Leonard, Hon. Leon, Atlantic City
Marcus, Joseph H., Los Angeles, Calif.
Mischlich, Hon. Richard, Egg Harbor

BERGEN COUNTY (2)

Society organized February 28, 1854. Meets on second Tuesday of each month, except July and August. Annual Meeting in May.

ACTIVE MEMBERS

Abarbanel, Milton G., 301 Rochelle av., Rochelle Pk.
Abbott, Charles C., 32 Main st., Lodi
Agayoff, John D., 127 S. Washington av., Bergenf'd
Alessi, Alfred A., 174 Merrison st., Teaneck
Alexander, Samuel, 12 S. Main st., Park Ridge
Alexander, Stewart F., 12 S. Main st., Park Ridge
Anderson, Reuben M., 15 Anderson st., Hackensack
Andrick, Eugene A., 99 Sheridan av., Hohokus
Angloletti, Louis V., 1617 Palisade av., Fort Lee
Appold, George D., 60 E. Church st., Bergenfield
Audi, Eugene H., 466 S. Maple av., Glen Rock
Baldwin, John F., 1474 Windsor rd., W. Englewood
Balze, Henry R., 147 Christie st., Leonia
Banta, Raymond E., 201 E. Ridgewood av., Ridgew'd
Barbash, Roslyn H. W., 835 Red rd., Teaneck
Barlow, G. Barton, 157 Engle st., Englewood
Barnes, William J., 155 Engle st., Englewood
Baron, Herbert A., 150 Terrace av., Hasbrouck Hts.
Basralian, Joseph B., 333 Wash'gt'n pl., Hasbr'k Hts.
Bassett, Samuel, 355 Washington av., Dumont
Bayer, Eric C., 307 E. Madison av., Dumont
Bednarz, Stephen, 219 Maple av., Wallington
Beres, Albert J., 492 Wood-Ridge av., Wood-Ridge
Berke, Raynold N., 430 Union st., Hackensack
Berkow, Abraham, 417 Main st., Hackensack
Blauvelt-Wells, Grace B., 76 Heights rd., Ridgew'd
Bleasby, Charles B., 136 Passaic st., Garfield
Blenkle, Victor A., 140 Chadwick rd., Teaneck
Bonanno, Peter J., 226 Engle st., Englewood
Bono, Joseph J., 647 Anderson av., Cliffside Park
Bookstaver, Barnet S., 241 Cedar lane, Teaneck
Bosch, Taeke. 290 E. Franklin Turnpike, Hohokus
Branon, Mark E., 16 W. Passaic av., Rutherford
Braun, Joseph C., 531 Broad av., Palisades Park
Bregman, Alexander, 2 Dempsey av., Edgewater
Brennan, Alfred T. V. Jr., 275 Engle st., Englewood
Brennan, Ralph J., 301 Plaza rd., Fair Lawn
Brescia, James, 7 E. Franklin Turnpike, Waldwick
Brown, John L., 1019 Cumbermede rd., Palisade
Brozyna, Mieczyslaw, 194 Carlton av., E. Rutherf'd
Buckley, Paul J., 159 Palisade av., Bogota
Bump, Samuel C., 505 E. Ridgewood av., Ridgewood

Burnham, Lyman, 229 Engle st., Englewood
Burns, Geoffrey C. H., County rd., Demarest
Burokus, William, 21 E. Pleasant av., Maywood
Busicco, Philip S., 131 Liberty rd., Englewood
Calabrese, Dino, 1022 Anderson av., Palisade
Caldwell, George W., 81 E. Clinton av., Tenafly
Campbell, Charles P., 397 Prospect av., Hackensack
Campbell, James M., 101 S. Central av., Ramsey
Candio, Vincent P., 366 Ridge rd., Lyndhurst
Carbone, Ralph, 2431 Lemoine av., Coytesville
Carroll, Thomas R., 754 Anderson av., Grantwood
Cartnick, Louis C., 228 Hillcrest av., Wood-Ridge
Caruso, Paul F., 194 Montross av., Rutherford
Catania, Joseph P., 140 Passaic st., Garfield
Catapano, John, 41 Winant av., Ridgefield Park
Chase, Kalman, Jr., 80 Sheridan av., Hohokus
Clarie, D'Arcy C., 558 Broad av., Ridgefield
Clark, Margaret A., Glen rd., Woodcliffe Lake
Cloud, Albert W., 139 Hugenot av., Englewood
Connor, Clarence A., 1586 Center av., Fort Lee
Cooper, Howard M., 37 Ridge rd., Rutherford
Coppoletta, Joseph M., 788 Kinderkam'k rd.,Riv.Ed.
Corn, David, 119 Park st., Ridgefield Park
Costabile, Vincent, 324 Second av., Lyndhurst
Cosulich, Livio, 886 Kinderkamack rd., River Edge
Coughlin, Joseph J., 396 Union st., Hackensack
Crandall, John K., 200 Main st., Fort Lee
Cropsey, Charles D., 168 Chestnut st., Rutherford
Curtis, Donald A., 241 Union st., Hackensack
D'Agostin, Henry, 243 Fulton ter., Cliffside Park
Dallio, Salvatore V., 463 Passaic av., Lodi
Daly, John F., 877 Queen Anne rd., Teaneck
D'Amato, Charles R., 324 Hoboken rd., E. Rutherford
Dana, Edward, 163 Prospect av., Hackensack
Davis, Harold, 170 S. Washington av., Bergenfield
Dayton, Spencer T., 86 W. Demarest av., Englewood
DeBiaso, Cornelius V., 9 W. Park pl., Rutherford
DeCecio, Thomas, 691 Palisade av., Cliffside Park
Delafrange, Kenneth M., 25 Westwood av., Westw'd
DeSanto, Anthony M., 377 Essex st., Hackensack
Deuell, William D., 190 Elm av., Hackensack
Dezer, Charles N., Jr., 210 Main st., Hackensack
Dickson, John D., 202 Larch av., Bogota
Dilger, Frederick G., 210 Main st., Hackensack
Dolan, Gerald J., 118 Broadway, Hillsdale
Doyle, George F., 80 Glenwood rd., Englewood
Drews, Francis F., Jr., 530 Broad av., Englewood
Driggs, Marshall F., 242 Engle st., Englewood
Edgerly, Sherburn E., 220 Engle av., Englewood
Edwards, J. Bennett, 144 Woodridge pl., Leonia
Ehrlich-Morrow, Laura E., 42 Ridge rd., Rutherford
Ellmers, Basil J., 304 Milford av., New Milford
Essertier, Edward P., 275 State st., Hackensack
Essertier, Harland C., 263 Franklin av., Ridgewood
Evans, J. Lawrence, Jr., 254 Christie Hgts.st., Leonia
Fadden, Francis J., Jr., 275 Engle st., Englewood
Farr, Walter J., 955 Queen Anne rd., Teaneck
Fechner, Fred J., 846 Garrison av., Teaneck
Fechner, Herta, 846 Garrison av., Teaneck
Fermaglich, Harry B., 881 Garrison av., Teaneck
Ferrante, Joseph, 309 Third st., Palisades Park
Ferrari, Andrew F., 196 Main st., E. Rutherford
Fietti, Vincent G., 112 Ridge rd., Lyndhurst
Finke, George W., 237 State st., Hackensack
Finke, John H. D., 19 Hudson st., Hackensack
Fitzhugh, William F., 190 Euclid av., Ridgefield Park
Fitzpatrick, Leo J., 541 Churchill rd., West Englew'd
Fliegel, William M., 85 W. Passaic st., Maywood
Freeland, Frank, 281 State st., Hackensack
Friedman, Abraham I., 405 State st., Hackensack
Friery, John F., 297 S. Washington av., Bergenfield
Garrett, Thomas A., 315 Park st., Hackensack
Gatti, Joseph D., 92 E. Hunter av., Maywood
Gershman, Joseph G., 185 E. Madison av., Dumont
Gilady, Raphael, 205 Union st., Hackensack
Giordano, William C., 948 Maple av., Ridgefield
Gittelsohn, Isador, 700 Kinderkamack rd., River Ed.
Gitterman, David A., 519 Engle st., Englewood
Glick, Bernard, 307 Stuyvesant av., Lyndhurst
Goldberg, David, 336 Westwood av., Westwood
Goldfarb, Abraham, 52 Chestnut st., Rutherford
Gordon, Sarah, 327 Cedar lane, Teaneck
Gorman, Robert B., 410 Kinderkamack rd., Oradell
Gould, Werner, 219 Passaic st., Hackensack
Grant, Russell B., 100 Prospect av., Hackensack
Greenfield, Arthur W., 50 Anderson st., Hackensack
Greenfield, William J., 50 Anderson st., Hackensack
Grimes, Robert R., 815 Elm av., Teaneck
Groff, Parker A., 159 Washington av., Little Ferry
Gross, Robert J., 786 Palisade av., Teaneck
Hagovsky, Albert J., 301 Hackensack st., Carlstadt
Hallett, Frederick S., 200 Passaic st., Hackensack
Halpern, Herman, 143 Engle st., Englewood
Harryman, William K., 271 Union st., Hackensack
Harwood, Harry L., 64 W. Central blvd., Palisades P.
Hawes, Vernon L., 63 Church st., Ramsey
Helff, Joseph R., 1367 Teaneck rd., W. Englewood
Heller, George, 460 Engle st., Englewood
Hensle, Otto S., 210 Main st., Hackensack
Hillsman, R. Bryan, 681 Queen Anne rd., Teaneck
Hirsch, John J., 191 Wallington av., Wallington
Hitzemann, Louis A., 35 Pangborn pl., Hackensack
Hoops, Harold J., 25 Woodland Park dr., Tenafly
Horowitz, Herman J., 872 Broad av., Morsemere
Hull, Donald B., 88 W. Ridgewood av., Ridgewood
Hunziker, George P., 435 Warwick av., W. Englew'd
Irwin, John H., 242 Engle st., Englewood
Irwin, Robert C., 51 Tenafly rd., Englewood
Jacobitti, Edmund E., 491 Maywood av., Maywood
Jaslow, Seymour P., Godwin av., Wyckoff
Jenkins, Alvah R., 40 Armory st., Englewood
Johnson, G. Leonard, 390 Booth av., Englewood
Johnson, Winton H., 210 Main st., Hackensack
Jordan, Walter L., 145 Engle st., Englewood
Kakascik, Emil J., 206 Palisade av., Garfield
Kaplan, Isaac, 901 Garrison av., Teaneck
Kastler, Franz, 54 Ames av., Rutherford
Keir, Floyd E., 308 Engle st., Englewood
Kelley, Charles B. P., 336 Engle st., Tenafly
Kennedy, Paul A., 147 Tenafly rd., Englewood
Kilts, Winfield S., 966 Garrison av., Teaneck
Kingma, John G., Goffle Hill rd., Midland Park
Kingslow, George L., 346 1st st., Hackensack
Klosterman, Julius A., River rd., Bogota
Knapp, Richard E., 25 Hudson st., Hackensack
Knight, William T., 210 Main st., Hackensack
Knowles, George M., 403 Prospect av., Hackensack
Knox, Charles A., 138 Bergen av., Ridgefield Park
Knox, Harriet L., 390 Union st., Hackensack
Kraissl, Cornelius J., 230 Kinderkam'k rd., Hack'ns'k
Kristal, John, 292 Main st., Hackensack
LaBarba, Peter J., 163 Washington pl., Hasbr'k Hts.
Lamberto, Vito A., 422 Stuyvesant av., Lyndhurst
Latona, Joseph A., 78 Main st., Lodi
Legato, Samuel F., 432 Palisade av., Cliffside Park
Lemmerz, Willard H., 135 Hackens'k st.,Wood-Ridge
Lesko, Stephen W., 234 Mt. Pleasant av., Wallington
Levitas, George M., 199 Fairview av., Westwood
Levitas, Irving M., Kinderkamack rd., Westwood
Levy, Jack D., 191 Union st., Hackensack
Lewis, Alice B., E. Saddle River rd., Saddle River
Little, Rufus R., Bergen Pines Hospital, Oradell
Littwin, Charles, 950 Queen Anne rd., Teaneck
Liva, Arcangelo, 100 Prospect av., Hackensack
Liva, G. Albin, Madison av., Wyckoff
Liva, Paul F., 280 Stuyvesant av., Lyndhurst
Liva, Vinicio G., 280 Stuyvesant av., Lyndhurst
Loman, Samuel G., 139 Jefferson av., Cresskill
Lombardi, Frank L., 25 E. Clinton av., Bergenfield
Lord, C. Donald, 76 W. Ridgewood av., Ridgewood

Lowe, Louise, 370 State st., Hackensack
Lueddecke, Roland E., 216 Randolph av., E.Rutherf'd
Lynch, Maurice M., 46 Anderson st., Hackensack
Lyons, Romola L. K., 171 Meadowbr'k rd., Englewood
Macaulay, Francis A., 819 Elm av., Teaneck
MacKellar, James M., 26 E. Clinton av., Tenafly
MacLaren, Philip J., 3 Tenafly Court, Tenafly
Mader, A. Ivan, Jr., 430 Union st., Hackensack
Magee, William P., 1009 Abbott blvd., Palisade
Mancene, Edward M., 225 Main st., Little Ferry
Mark, Harold I., 1022 Garrison av., Teaneck
Markley, Luther A., Holy Name Hosp., Teaneck
Marx, Frederick J., 539 Kinderkam'k rd.,River Edge
Mason, Stuart A., 756 E. Ridgewood av., Ridgewood
Mayer, David M., 166 Ridge rd., Rutherford
McCormack, Frank C., 95 Tenafly rd., Englewood
McFeely, Percy R., 242 Palisade av., Bogota
McIlveen, Marion, 260 Godwin av., Ridgewood
McLane, A. Donald, 498 Engle st., Englewood
McLeod, Harry J., 71 Forest rd., Tenafly
McWhorter, John E., 115 Grand av., Englewood
Mears, William G., 216 Hillside av., Leonia
Megibow, Harold J., Main st., Ramsey
Metz, Henry, Summit av., Hackensack
Meyer, Howard M., 400 Maple Hill dr., Hackensack
Miller, Herbert G., 176 Union av., Rutherford
Modrys, Walter F., 1400 Palisade plaza, Hudson Hts.
Mores, Herbert R., 321 Union st., Hackensack
Moss, Jack W., Maple av., Wyckoff
Muller, Frederick L., 511 Broad st., Carlstadt
Mulligan, Luke A., 230 Fort Lee rd., Leonia
Myers, Norman V., 134 Magnolia av., Tenafly
Naclerio, Amedeo, 207 Hackensack st., Wood-Ridge
Nemiroff, Nathan, 348 Kinderkamack rd., Oradell
Netz, Lester W., 414 Main st., Hackensack
Newmann, Monroe E., 24 W. Salem st., Hackensack
Nicol, Lorenz C., 360 Larch av., Bogota
Olpp, John L., 49 Ivy lane, Tenafly
Olson, Vendela E., 100 Prospect av., Hackensack
Oren, Hyman, 74 Perry st., Park Ridge
Padden, Aloysius F., 15 Anderson st., Hackensack
Pagano, Peter, 324 Franklin av., Ridgewood
Pallen, Conde deS., 6 Passaic st., Rochelle Park
Patti, Frank A., 241 Broad av., Leonia
Pedevill, Joseph R., 232 Highland av., Palisades Park
Pellegrini, Vincent J., 315 Rochelle av.,Rochelle P'k
Perham, Roy G., 248 Boulevard, Hasbrouck Hts.
Pettit, Harry H., 138 Franklin av., Ridgewood
Phillips, Walter, 109 E. Palisade av., Englewood
Pindar, Arthur W., 627 Queen Anne rd., Teaneck
Pindar, Irene D., 164 Selvage av., West Englewood
Pindar, William A., Jr., 59 Bradley av., Bergenfield
Pingitore, Eufelia, 30 Martin ter., Hackensack
Policastro, Nelson C., 378 Union st., Hackensack
Pollack, Roy, 715 Palisade av., Cliffside Park
Prall, Henry E., 755 Anderson av., Cliffside Park
Prather, Charles G., 25 Westwood av., Westwood
Prather, John W., 155 Washington av., Dumont
Protzman, Thomas B., 314 Engle st., Englewood
Prout, William B., 88 W. Forrest av., W.Englewood
Pullen, Guy F., 111 Leonia av., Leonia
Rader-Hoheb, Katherine, 5 Lincoln av., Rutherford
Rappaport, Doris I., 1363 Sussex rd., W. Englewood
Ravits, Everett C., 418 Main st., Hackensack
Re, Natale M., 1003 Dearborn rd., Palisade
Reich, Samuel B., 286 Union st., Hackensack
Reid, Erwin W., 125 Marsellus pl., Garfield
Reinhold, H. E., 441 W. Englewood av., W.Englewood
Reitnauer, John S., 6 Standish ct., Tenafly
Rhodes, Harry, Jr., 171 Terrace av., Hasbrouck Hts.
Richards, Ernest W., 374 DeWolf pl., Hackensack
Richardson, Charles A., Main st., Closter
Ringewald, Robert H., 284 Broad av., Leonia
Roberts, Charles D., 188 Sherwood pl., Englewood
Romano, Anthony M., 159 Westervelt av., Tenafly
Roth, Daniel B., 836 Garrison av., Teaneck
Rowohlt, George O., 150 E. Madison av., Dumont
Roylance, F. Dean, Jr., St. Nicholas av., Haworth
Rube, Joseph A., 145 Prospect st., Ridgewood
Rucker, William C., 408 Main st., Hackensack
Ruoff, Andrew C., III, 24 Cleveland av., Rivervale
Ryley, Harold W., 1 Lincoln pl., E. Rutherford
Sandler, Moses, 2013 Center av., Fort Lee
Sandler, Samuel A., Laurelton Parkway, Teaneck
Sarajian, Aram M., 131 Ayres ct., W. Englewood
Sarla, Michael, 55 Hudson st., Hackensack
Scerbo, Ernest, 33-14 Broadway, Warren Point
Schaberg, Frank J., 263 Anderson st., Hackensack
Scheer, Eli, 885 Queen Anne rd., Teaneck
Schmidt, Walter W., 386 Palisade av., Cliffside Park
Schretzmann, Rudolph C., 289 Traf'lg'r st.,W.Eng'w'd
Schwartz, Leon J., 88 Park av., Rutherford
Scullion, Arthur A., 460 Anderson av., Cliffside Park
Sealey, Henry J., 79 Washington av., Dumont
Segard, Christian P., 204 Glenwood av., Leonia
Seiler, Benjamin, 580 Palisade av., Cliffside Park
Sexton, Edward V., 936 Queen Anne rd., Teaneck
Seymour, Edward T., 55 Hillside av., Tenafly
Silverman, Mendel, 84 Park av., Rutherford
Singer, Marie J., 139 E. Madison av., Dumont
Skvarla, John A., 17 Koster st., Wallington
Sloane, Milton B., 128 W. Hudson av., Englewood
Smith, Nehemiah E., 29 Bennett rd., Englewood
Snedecor, Spencer T., 210 Main st., Hackensack
Solworth, Lee, 308 Engle st., Englewood
Somers, Williard H., 157 Engle st., Englewood
Sosnow, Louis M., 51 Central av., Hillsdale
Sperber, Thomas J., 714 Cedar lane, Teaneck
Spicola, Louis A., 294 Union st., Lodi
Spiegelglass, Abraham B., 417 Main st., Hackensack
Spranz, William S., 546 Oradell av., Oradell
Stein, Frederick, 620 Ridge rd., Lyndhurst
Sullivan, John A., 764 Queen Anne rd., Teaneck
Tennis, Edgar M., 375 Engle st., Englewood
terKuile, Reinold W., 88 W. Ridgewood av.,Ridgew'd
Tether, Russell K., Main st., Closter
Tomlins, Francis I., 97 Madison pl., Ridgewood
Tyson, Frances B., 101 Leonia av., Leonia
Vanderbeek, Stuart W., 143 Engle st., Englewood
Vandersluis, Harold H., 86 S. Main st., Park Ridge
Van Dyke, Joseph S., 42 Palisade blvd., Palisades Pk.
Vann, Dorothea D., 179 Hillside av., Englewood
Vann, Felix H., 179 Hillside av., Englewood
Van Riper, William D., 441W.Eng'w'd av.,W.Eng'w'd
Van Winkle, Charles I., 79 Ridge rd., Rutherford
Verdon, Robert E., 682 Anderson av., Cliffside
Vita, Frank J., 695 Palisade av., Cliffside Park
Vroom, William L., 88 W. Ridgewood av., Ridgewood
Walker, Nelson C., 15 Anderson st., Hackensack
Ward, Mary, 30 Engle st., Tenafly
Warren, Charles B., 181 Prospect av., Bergenfield
Weiss, Abram, 509 Warwick av., West Englewood
Weiss, Samuel A., 786 Palisade av., Teaneck
White, Frank S., 916 Red rd., Teaneck
Whitman, Lloyd B., 7 W. Clinton av., Bergenfield
Widetsky, Alfred, 85 Broadway, East Paterson
Williams, Edith B., 70 Anderson st., Hackensack
Williams, William C., 9 Ridge rd., Rutherford
Willis, Benedict P., 185 Montross av., Rutherford
Wilson, Harrison B., 430 Union st., Hackensack
Winter, Gladys C., 790 Grange rd., Teaneck
Witkoff, Ben., 215 Terrace av., Hasbrouck Heights
Wolfe, Edward E., 895 Queen Anne rd., Teaneck
Wollack, Alfred, 74 Perry st., Park Ridge
Wolowitz, Harry B., 20 Spring Valley av., Hack'ns'k
Worcester, George F., 220 Engle st., Englewood
Wren, James C., Main st., Closter
Wry, Orlin V., 95 High st., E. Rutherford
York, James L., 331 River rd., New Milford

ASSOCIATE MEMBERS

Catanzaro, Vincent J., 316 Midland av., Garfield
D'Agati, Vincent, 174 Merrison st., Teaneck
Drucker, Victor, 786 Palisade av., Teaneck
Fioretti, Ralph J., 315 Rochelle av., Rochelle Park
Krudener, Robert D., 230 Fulton ter., Cliffside Park
Law, Harrison E., 397 Prospect av., Hackensack
McKinney, Thomas S., 20 Grand av., Ridgefield Pk.
Meehan, James S., Jr., 503 Linden av., Teaneck
Orlando, Lorenzo, 78 Ross av., Hackensack
Rentrop, Charles A., Jr., 364 E.Ridgew'd av.,Ridgew'd
Ross, Bernard, 30 E. Passaic st., Maywood
Rusin, Michael, 81 Monroe st., Garfield
Scheip, James R., II, 356 Maple av., Oradell
Schultz, Leo P., 232 Franklin Tpke., Allendale
Siegel, Simeon, 167 Washington av., Dumont
Spitaleri, Liborio N., 343 Union st., Lodi
Steneck, Gustav G., 275 River rd., Bogota
Williams, John R., 681 Anderson av., Cliffside Pk.

COURTESY MEMBERS

Carey, Benjamin W., Westwood
Coca-Fernandez, Arthur, Oradell
Denison, Ward C., Paterson
Duffy, Robert W., Hasbrouck Heights
Hambright, Arthur M., Ramsey
Harreys, Charles W., Ridgewood
Lewin, Michael L., Tenafly
Liddy, Frank J., Mahwah
Opitz, Russell B., Palisade
Salter, Kent, Paterson
Scialli, Vincent A., Ithaca, N. Y.
Twinem, Francis P., Hackensack

HONORARY MEMBERS

Burbank, Hugh E., Lyndhurst
Clock, Ralph O., Scarsdale, N. Y.
Hallett, Frederick S., Hackensack
Proctor, James W., Tenafly
Tidwell, George W., Rutherford

BURLINGTON COUNTY (3)

Society organized May 19, 1829. Regular meetings on second Thursday evening of each month except June, July and August, at Riverton Country Club, Riverton. Annual Meeting in May.

ACTIVE MEMBERS

Anderson, Richard D., 465 High st., Burlington
Atkinson, James Q., State Colony, New Lisbon
Barton, Amy S., 509 Chester av., Moorestown
Betts, R. Winfield, 22 N. Main st., Medford
Boudwin, Norman K., 64 Church st., Beverly
Bray, William E., 41 Elizabeth st., Pemberton
Buckley, Richard T., Jr., 111 E. Main st.,Maple Shade
Busansky, Samuel T., Trenton rd., Browns Mills
Ciclone, Edward, 621 Highland av., Palmyra
Curtis, Howard C., 224 E. Main st., Moorestown
Darlington, Emlen P., New Lisbon
Davis, E. Vernon, 306 E. Main st., Moorestown
Davis, Jacob M., 1400 High st., Burlington
Dickson, T. Bruce, 408 Main st., Riverton
Elwell, Alfred M., Jr., 149 E. Main st., Moorestown
Fahrenbruch, Fred'k D., 101 Garden st., Mt. Holly
Fischbach, Adolph D., 108 Hanover st., Pemberton
Geary, Russell D., 337 Bridgeboro rd., Riverside
Haldeman, Robert E., 34 Garden st., Mt. Holly
Hale, Matthew J., 467 High st., Burlington
Hartman, Luther M., 111 E. Main st., Maple Shade
Hebble, Howard M., 320 Chester av., Moorestown
Hornberger, J. Howard, 4th & Main sts., Roebling
Hunter, Edward R., 321 Union av., Delanco
Krasnitz, Alexander, Fairview Sana., New Lisbon
Kuder, Joseph M., 104 Garden st., Mt. Holly
Landis, Harry P., Jr., 901 Columbia av., Palmyra
LeFavor, Dean H., 619 Morgan av., Palmyra
Leonard, Bernard, 33 W. Union st., Burlington
Longsdorf, Harold E., Bartram av., Mt. Holly
Love, Elizabeth F., 142 E. Oak av., Moorestown
Lucas, W. Fred, 23 W. Broad st., Burlington
MacNeal, Perry S., 417 Chester av., Moorestown
Mark, Harry B., 600 Elm ter., Riverton
Mazur, Edward F., 540 Bridgeboro rd., Riverside
Mendenhall, Clinton D., 412 F'rnsw'th av.,Bordent'n
Metzer, Emma P. W., 430 Fairview st., Riverside
Metzer, Freeman W., 428 Fairview st., Riverside
Mills, Charles S., 106 Lippincott av., Riverton
Mulford, William P., 202 Warren st., Beverly
Munro, Charles A., Main st., Marlton
Newcomb, Marcus W., Browns Mills
Peacock, Arthur B., 201 E. Main st., Moorestown
Rachunis, Michael, 5th & Riverside avs., Roebling
Robbins, Morris A., 39 W. Main st., Columbus
Rodman, E. Warren, 503 Cooper st., Beverly
Sand, Abraham B., 207 E. Union st., Burlington
Schaeffer, Alan M., 229 Willow st., Delanco
Schisler, Milton M., 2nd & Church sts., Florence
Shapiro, Charles S., S. Forklanding rd., Maple Shade
Small, E. Lester, 30 Branch st., Medford
Sparks, Paul R., 102 W. Broad st., Burlington
Steitz, John A., 200 Garden st., Mt. Holly
Stokes, S. Emlen, 129 Chester av., Moorestown
Strenski, John, 330 Fairview st., Riverside
Summey, Thomas J., 800 Golf View rd., Moorestown
Thorne, Nathan, 68 E. Main st., Moorestown
Tracy, George T., 222 Warren st., Beverly
Ulmer, D. H. B., 199 Chestnut st., Moorestown
Viteri, Luis E., 214 Main st., Mt. Holly
Voorhis, Charles F., 330 Morgan av., Palmyra
Voss, John C., 634 Thomas av., Riverton
Wagner, J. George, Riverbank, Delanco
Wells, William C. V., 220 Hazel av., Delanco
Wescoat, George N. A., 202 W. Main st., Moorestown
Whitaker, John C., 402 Lippincott av., Riverton
Whitcher, Burr, 44 Broad st., Mt. Holly
Wildman, Edward D., 119 Chester av., Moorestown
Wyman, Edward H., 100 E. Broad st., Burlington
Ziccardi, Anthony V., Mar. Hague Mat. Hos.,Jer.City

HONORARY MEMBER

Thorne, Nathan, Moorestown

CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets first Tuesday in each month, October to May, inclusive, with an outing in June. Annual Meeting in May.

ACTIVE MEMBERS

Amato, Charles P., Box 612, Camden
Anderson, Wm. M., 20 Kings H'way, W., Hadd'nf'd
Andrus, David L., 805 Cooper st., Camden
Asbell, Nathan, 326 Cooper st., Camden
Assante, M. Hugo, 120 White Horse pk., Clementon
Athey, Kenneth L., 3616 Westfield av., Camden
Baker, Banks S., 618 Benson st., Camden
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, Kirk B., 1303 Princess av., Camden
Barnshaw, Harold D., 406 Cooper st., Camden
Barroway, James N., 2714 Westfield av., Camden
Becker, C. Frederick, 620 Benson st., Camden
Beideman, Casper M., 5 W. Maple av., Merchantville
Bekampis, Eugene H., 315 E. Maple av., Merchantv'e
Bentley, David F., Jr., 406 Cooper st., Camden
Bernell, Stanley P., 1207 Haddon av., Camden
Betancourt, Raul R., 406 Cooper st., Camden
Bianco, John J., 523 Cooper st., Camden
Bibighaus, Warren Y., 313 4th av., Haddon Heights
Bowen, Robert N., 419 Cooper st., Camden
Boysen, Otto T., 2704 Westfield av., Camden
Braun, William, 406 Cooper st., Camden
Breme, Julius C., 523 Walnut av., Laurel Springs
Brennan, Charles L. S., 14 S. Broadway, Gloucester
Brennan, John P., 429 Cooper st., Camden
Brown, Marcus, 2 White Horse Pike, Haddon Hts.
Brown, Stanley L., 517 Cooper st., Camden
Browning, Wm. J., 134 N. Centre st., Merchantville
Burns, Wilmer F., 267 White Horse Pike, Audubon
Bush, Ralph K., 23 E. Maple av., Merchantville
Butler, Samuel S., 1100 Kaighn av., Camden
Carlander, Oswald R., 130 N. Broadway, Camden
Casselman, Arthur J., 301 N. Second st., Camden
Cavalli, Ralph D., N. Y. Shipbuilding Corp., Camden
Clark, Ernest W., 414 Cooper st., Camden
Clark, Morris B., W. Pine and Atl. avs., Audubon
Cohen, Paul, 500 State st., Camden
Collier, Martin H., 406 Cooper st., Camden
Conlen, Richard, 523 Haddon av., Camden
Connell, James, 337 Monmouth st., Gloucester
Cooper, Robert A., 7137 E. Park av.,PennsaukenTwp.
Coxson, Harold P., Laurel rd., Stratford
Crist, Walter A., 432 Virginia av., West Collingsw'd
Crowley, Joseph W., 4005 Westfield av., Camden
Cunningham, Joel B., 801 Cooper st., Camden
Davis, Albert B., 511 Cooper st., Camden
Decker, Henry B., 527 Penn st., Camden
Deibert, Irvin E., 538 Cooper st., Camden
Del Duca, Vincent P., 514 Cooper st., Camden
Dempsey, J. Harvey, 66 Washington av., Berlin
Denbo, Elic A., 596 Benson st., Camden
Dickensheets, Jas. G., 4405 Westf'd av.,Penns'k'nTp.
Di Ielsi, Anthony J., 1013 S. 5th st., Camden
D'Imperio Francesco, 411 Cooper st., Camden
Driscoll, C. D., 475 White Horse Pike, W. Col'ngsw'd
Drossner, Jacob L., 1300 Park Blvd., Camden
Ebner, Paul G., 408 Overhill rd., Haddonfield
Ellis, Alexander, 519 Broadway, Camden
Ewing, Leslie H., 10 Broad st., Berlin
Eynon, Harold K., 538 Cooper st., Camden
Eynon, James R., 20 E. Knight av., Collingswood
Farrell, Edgar A. H., 26 Kings Highway,W..H'd'nf'ld
Fessman, John W., Clements Bridge rd., Runnemede
Filkins, Cedric E., 412 White Horse Pike, Audubon
Fisher, Stella C., 4401 Westf'd av., Pennsauken Twp.
Frantz, Max K., 624 S. 5th st., Camden
Fridrich, Harry E., 4172 Federal st., Camden
Friedenberg, Sidney, 2990 Alabama rd., Camden
Gamon, Robert S., 514 Cooper st., Camden
Geissler, Elmer E., 327 Monmouth st., Gloucester
German, George B., 15 W. Walnut av.,Merchantville
Gilbert, Philip D., 514 Cooper st., Camden
Girardo, Anthony J., 22 Taunton av., Berlin
Glover, L. L., 53 Kings Highway, W., Haddonfield
Goldman, Samuel, 527 Cooper st., Camden
Goldstein, Hyman I., 1425 Broadway, Camden
Gordon, Milton H., 12 N. 27th st., Camden
Gosper, Ralph W., 5719 W'stf'd av., Penns'kenTwp.
Grenhart, George W., 714 Market st., Camden
Griffey, William C., 1049 Haddon av., Collingswood
Griscom, Lee E., 604 Broadway, Camden
Hadley, C. Frazer, 210 W. Maple av., Merchantville
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont
Haines, Keith E., 300 Broadway, Camden
Haines, Mabel C. S., 600 White Horse Pike, Audubon
Halbeisen, William A., 511 Cooper st., Camden
Hallinger, Earl S., 517 Cooper st., Camden
Hammett, Lee J., 760 N. 27th st., Camden
Hanson, Alfred S., 33 E. Cuthbert rd., Westmont
Harbeson, James P., III, 403 Cooper st., Camden
Hays, Roy G., 527 Haddon av., Collingswood
Hemphill, Everett H., 274 Kings H'way, E., Had'nf'd
Hessert, Edmund C., 417 Cooper st., Camden
Hirshorn, Arthur, 539 Monmouth st., Gloucester
Hofer, William R., 125 Main st., Williamstown
Hollinshed, Beulah S., 600 Benson st., Camden
Horner, John I., 137 W. Kings Highway, Audubon
Howard, J. Edgar, 67 Kings H'way, W., Haddonf'd
Hughes, A. Joseph, 3rd & Cooper sts., Camden
Hughes, Frank J., 429 Cooper st., Camden
Hughes, Thomas E., 223 Cooper st., Camden
Hummel, Ernest G., 414 Cooper st., Camden
Husted, Gerald W., 306 Eighth av., Haddon Heights
Imhoff, Robert E., 527 Penn st., Camden
Ironside, Paul A., 144 North dr., Haddonfield
Jablonski, John J., 1405 Kenwood av., Camden
Jack, H. Wesley, 538 Cooper st., Camden
Jackson, Chas. H., 1250 Park Blvd., Camden
Johnson, Herbert F., 429 Cooper st., Camden
Jones, John C., 805 Princeton av., Camden
Judson, G. Vernon, Jr., 722 Redan av., Haddonfield
Kain, Thomas M., 403 Cooper st., Camden
Kain, Thomas M., Jr., 403 Cooper st., Camden
Kay, Albert E., 5 W. Chestnut av., Merchantville
Keller, Earl B., Jr., 604 White Horse Pike, Oaklyn
Kennedy, George R., 517 Cooper st., Camden
Kerdasha, Richard F., 937 Monmouth st., Gloucester
Keyser, David, 1518 Baird av., Camden
Kimler, William D., 400 Collings av., Collingswood
Kinney, Albert G., 609 Clinton av., Haddonfield
Klarich, Philip, 512 Broadway, Camden
Kline, Oram R., 514 Cooper st., Camden
Klinger, John S., 1452 Mt. Ephraim av., Camden
Kutner, Charles, 211 N. Fifth st., Camden
Larossa, Ernest A., 561 Benson st., Camden
Lee, Benjamin F., 1468 Bradley av., Camden
Lee, Thomas B., 622 Cooper st., Camden
Locke, Henrik W., 243 W. Main st., Moorestown
Lovett, Joseph C., Municipal Hospital, Camden
MacAlpine, Kenneth B., 500 Chews Ldg. rd.,Had'nf'd
Magee, Edward S., 201 White Horse Pike, Audubon
Magee, Russell S., 201 White Horse Pike, Audubon
Mahaffey, J. Lynn, 406 Warwick rd., Haddonfield
Maldeis, Albertos M. K., 117 N. Sixth st., Camden
Manser, Ernest E., 321 Haddon av., Collingswood
Marcarian, Henry G., 917 Cooper st., Camden

McAfoos, Louis G., Jr., 608 Eldridge av.,W. Coll'gsw'd
McCarthy, Arthur M., 2772 Federal st., Camden
McConaghy, Thomas P., 10th & Cooper sts., Camden
McDermott, Vincent T., 509 State st., Camden
McGlade, Thomas H., 1225 Walnut ave., W.Col'gsw'd
McWilliams, Charles E., Church st., Blackwood
Mecray, Paul, Jr., 405 Cooper st., Camden
Mecray, Paul M., 405 Cooper st., Camden
Meyer, Eugene A., 427 Cooper st., Camden
Meyer, George P., 410 Haddon av., Camden
Murray, Edwin N., 130 N. Broadway, Camden
Musulin, Nicholas R., 514 Cooper st., Camden
Newmeyer, Joseph, 47 S. 27th st., Camden
Ondovchak, M. Frederic, Kings H'way, Mt. Ephraim
Ornaf, I. Edward, 1145 Thurman st., Camden
Osborn, Edward G., 3194 Alabama rd., Camden
Paisley, Ellwood S., 501 White Horse Pk., Haddon H.
Palmisano, Vincent S., 13 W. 6th av., Runnemede
Phillips, Claude B., 885 Haddon av., Collingswood
Pike, Charles E., 4 E. Haddon av., Oaklyn
Pinsky, Harry A., 209 S. 6th st., Camden
Pratt, Arthur G., 516 Cooper st., Camden
Price, Henry S., Jr., 150 Frazer av., Collingswood
Principato, Roberto, 402 Walnut st., Camden
Raban, Reginald J., 1185 Yorkship Square, Camden
Rapp, Robert F., 994 Haddon av., Collingswood
Read, William T., Jr., Cooper Hospital, Camden
Reilly, Joseph, 600 Newton av., Oaklyn
Repici, Anthony J., 212 Haddon av., Haddonfield
Rhone, David S., 1202 Haddon av., Camden
Richardson, Emma M., 581 Stevens st., Camden
Riegert, Louis C., 808 Kings H'way, Haddon Hts.
Ristine, Edwin R., 123 Maple av., Westville
Roberts, Joseph E., Jr., 403 Cooper st., Camden
Rosenberg, Hyman, 318 Cooper st., Camden
Rosner, Edwin, 814 Haddon av., Collingswood
Rudolph, John P., 108 W. Maple av., Merchantville
Russell, Karl S., 101 Dill av., Collingswood
Russell, Marie E., 583 Haddon av., Collingswood
Ruttenberg, Max, 303 Cooper st., Camden
Ryan, Lawrence W. F., 922 Haddon av., Collingsw'd
Schall, Reuben E., Seventh & Elm sts., Camden
Scheffler, Wilhelm A. H., 511 Cooper st., Camden
Schellenger, Edward A. Y., 429 Cooper st., Camden
Schrack, Helen F., 216 N. Fifth st., Camden
Schwartz, Henry C., Raritan av., Atco
Seiberling, Joseph D., 225 Redman av., Haddonfield
Seto, Stanford P. T., Box 138, Blackwood
Shaen, Edward, 701 N. 6th st., Camden
Shafer, Albert H., 405 Cooper st., Camden
Shafer, F. William, 634 Penn st., Camden
Sharp, Reuben L., 719 Cooper st., Camden
Shaw, Ernest B., 811 Collings av., W. Collingswood
Shaw, Ned, 514 Cooper st., Camden
Sheaffer, Clinton P., 241 Kings H'way, E., Had'nf'd
Shemeley, William G., Jr., 7 Haddon av., Camden
Sherk, A. Lincoln, 2647 Westfield av., Camden
Shipman, James S., 514 Cooper st., Camden
Shipps, Hammell P., 719 Cooper st., Camden
Shope, Edward P., 130 N. Broadway, Camden
Shull, Elliott C., 517 Cooper st., Camden
Sieber, Isaac G., 204 Merchant st., Audubon
Skyer, Joseph, 3400 Federal st., Camden
Smith, Bertram H., 1000 Kings Highw'y,Hadd'nHts.
Smith, James D., 831 Stokes av., Collingswood
Smith, Wilbur A., 393 Seventh av., New York City
Snape, William J., 573 Stevens st., Camden
Sochacki, Alexander, 1478 Mt. Ephraim av., Camden
Stein, Joseph M., 5313 Sherwood ter., Mechantville
Stephenson, Daniel H., N.J. State Hospital, Marlboro
Stone, Frank P., 234 Fairmount av., Laurel Springs
Storer, Alexander, Jr., 563 Haddon av., Collingswood
Straus, Frederick W., 2708 Westfield av., Camden
Sufrin, Emanuel, 1529 Wildwood av., Camden
Sullivan, Claude C., Jr., 111 Hemlock av.,LaurelSp'gs
Summerill, Garnett, 330 Cooper st., Camden
Swiecicki, M. E., 317 Clements Bridge rd., Barr'ngton
Tatem, Henry R., Jr., Pine st.&Atlantic av.,Audubon
Thompson, P. H., 4612 W'stf'd av., Pennsauken Twp.
Traganza, Robert W., 428 Richey av., W.Collingsw'd
Warwick, Ralph A., 3300 Federal st., Camden
Waugh, Bascom S., 1882 S. 10th st., Camden
Weimann, Max L., 803 Station av., Haddon Heights
Weiner, Herman R., 527 Cooper st., Camden
Whalen, Edward C., 942 Cooper st., Camden
Wiant, Herman E., 120 Windsor av., Haddonfield
Williams, William C., Black Horse Pk., Haddon Hts.
Wilson, Lester R., 3320 Federal st., Camden
Winter, Carl M., 1518 Collings rd., Camden
Witkowski, Joseph L., 1450 Mt. Ephraim av., Camd'n
Wright, Ralph S., 517 Cooper st., Camden
Wroblewski, Benj. M., 1166 Thurman st., Camden
Yasskin, Hymen E., 575 Stevens av., Camden
Ziegler, Frederick, Vet. Adm. Ctr., Los Angeles,Calif.

HONORARY MEMBERS

Clement, Lavinia B., Haddonfield
Eaton, Arthur T., Haddon Heights
Lyon, Leslie C., Runnemede
Martin, William, Haddonfield
Pratt, William H., Camden
Rossell, Edward W., Colwick
Van Sciver, John E. L., Haddonfield

CAPE MAY COUNTY (5)

Society organized December 18, 1883. Eight regular meetings each year. Meets on fourth Tuesday, October to May inclusive. Semi-annual meeting in October. Annual Meeting in May.

ACTIVE MEMBERS

Barrows, Victor I., 106 W. 11th st., Wildwood
Bernheisel, Louis E., Marshallville rd., Tuckahoe
Brooks, George M., 18 N. Main st., Cape May Ct. H.
Cameron, C. Paul, 720 Shore rd., Somers Point
Cohen. Maurice B., Pine & Pacific avs., Wildwood
Cooper, Jules, 723 Washington st., Woodbine
Cornwell, Robert A., 702 Sixth av., Ocean City
Crowe, Aldrich C., 735 Atlantic av., Ocean City
Cryder, Millard C., 109 Mechanics av., Cape M. Ct. H.
Dandois, George F., 220 E. Wildwood av., Wildwood
Darby, C. Eugene, 620 Atlantic av., Ocean City
Eisenhower, J. S. D., 154 E. Spicer av., Wildwood
Fath, Marcus A., 108 E. Glenwood av., Wildwood
Haines, F. B. Lane, 503 Ninth st., Ocean City

Haines, Willits P., 503 Ninth st., Ocean City
Hauck, Francis A., 4th & Landis avs., Sea Isle City
Hirsch, Arthur, 811 DeHirsch av., Woodbine
Hornstine, Harry H., 4004 Pacific av., Wildwood
Hughes, Harold F., Ocean st. & Columbia av.,CapeM.
Hughes, Samuel B., 246 E. Pine av., Wildwood
Markowitz, Isidor, 115 Broadway, West Cape May
Mazzotta, Samuel, 5806 Pacific av., Wildwood
Moir, John A., 18 N. Main st., Cape May C'rt House
Monosson-Friedland, Ida, 200 N. East av., Vineland
Moon, Alexander C., 126 Decatur st., Cape May
Newcomer, Harry S., 1048 Washington st., Cape May
Pettit, Herschel, 807 Wesley av., Ocean City
Pettit, Paul H., 807 Wesley av., Ocean City
Schwarz, Leopold, 237 E. Pine st., Wildwood
Smith, Marcia V., 821 Wesley av., Ocean City
Snyder, James A., Franklin st.& Sewell av.,CapeM.
Steel, William A., Beesley's Point
Townsend, John B., 824 Wesley av., Ocean City
Tyson, Edward B., 391 55th st., Ocean City
Wallen, Benjamin B., 217 E. Pine av., Wildwood
Way, Clarence W., 4515 Landis av., Sea Isle City
Whiticar, John H., Box 235, Ocean City
Yingling, Paul L., 804 Wesley av., Ocean City

HONORARY MEMBERS

Quigley, Frederic J., Union City
Ulmer, Chester I., Gibbstown

CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets on the second Tuesday of October, December, February, April and June. Annual Meeting in April. Special scientific meetings are held in tbe evening in November, January, March and May.

ACTIVE MEMBERS

Aitken, Frank J., 62 N. Pearl st., Bridgeton
Anastor, Herbert C., 641 Wood st., Vineland
Bacon, Mary, 278 E. Commerce st., Bridgeton
Baker, Hugh W., 8th & Elmer sts., Vineland
Bellak, Ellis R., Leesburg
Berkowitz, Benjamin, 188 E. Commerce st.,Bridgeton
Bostwick, Delazon S., Cumberland Hotel, Bridgeton
Branin, Howard S., 200 W. Main st., Millville
Brown, Robert C., 318 N. Second st., Millville
Butcher, Charles, Heislerville
Carll, Jesse W., 129 Broad st., Bridgeton
Corson, Kenneth E., 25 S. Myrtle st., Vineland
Cunningham, Charles, Jr., 716 Wood st., Vineland
Davies, George A., 53 Front st., Elmer
Day, Samuel T., Main st., Port Norris
DeSantis, Orazio J., 131 N. Third st., Millville
Friedland, Arnold J., 200 N. East av., Vineland
Fromkin, Charles, 20 Bank st., Bridgeton
Garrison, Sherman, 108 W. Commerce st., Bridgeton
Garrison, W. Sherman, Main st., Cedarville
Gray, Charles M., 6th & Grape sts., Vineland
Greene, Edwin C., 61 N. Pearl st., Bridgeton
Gricco, Anthony L., 306 S. East av., Vineland
Harris, Maurice N., 205 Irving av., Bridgeton
Hendrickson, Harold W., Edgewood av., Cedarville
Henry, Norman, 643 Wood st., Vineland
Kauffmann, Louis J., 228 N. Second st., Millville
Knowles, James S., 318 N. Second st., Millville
Kolbe, Joseph T., 119 S. Second st., Millville
Kratka, William H., 188 N. Pearl st., Bridgeton
Kump, Albert B., 39 Lake st., Bridgeton
Lang, Paul, 32 W. Commerce st., Bridgeton
Loder, Horace B., 225 E. Commerce st., Bridgeton
Lore, Harry E., Main st., Cedarville
Lyon, Earl C., 194 E. Commerce st., Bridgeton
Madi, Risley J., 735 Montrose st., Vineland
Magolda, Anthony F., 727 Grape st., Vineland
Marchione, Nicholas E., 105 S. East av., Vineland
Mayhew, Charles H., 329 Pine st., Millville
Mezzetti, Alfred F., 220 S. Sixth st., Vineland
Myatt, Leslie E., 98 N. Pearl st., Bridgeton
Neal, Charles B., Pine & Third sts., Millville
Palladino, Alessandro, 86 W. C'mm'rce st., Bridgeton
Pastore, Mario, East av. & Grape st., Vineland
Phillips, Ralph S., 81 Broad st., Bridgeton
Pino, Anthony, 196 Irving av., Bridgeton
Ramsey, F. Muriel, 310 E. Pine st., Millville
Rosen, Sol, 214 N. Second st., Millville
Rosiello, Louis E., 712 Wood st., Vineland
Ruggieri, Pasquale, 803 Elmer st., Vineland
Scott, Leonard G., 496 E. Commerce st., Bridgeton
Sewall, Arthur D., 52 N. Pearl st., Bridgeton
Sharp, Charles E., Main st., Port Norris
Sheppard, Alfred G., 309 Broad st., Elmer
Sheppard, Muse A., Broad & Penn sts., Elmer
Sheppard, Thomas S., 21 E. Vine st., Millville
Siegel, Sidney L., 227 N. Second st., Millville
Sydoriak, Vladimir L., 111 N. Third st., Millville
Thalheimer, Edward J., 7th & Plum sts., Vineland
Thomas, George N., 8th & Grape sts., Vineland
Walker, Ada H., 635 Landis av., Vineland
Walker, H. Burton, 635 Landis av., Vineland
Ware, Carl N., Bridgeton rd., Shiloh
Whaland, Berta, 117 Atlantic st., Bridgeton
Wilson, Charles W., 636 Wood st., Vineland
Wilson, Herbert H., 24 Bank st., Bridgeton
Winslow, John H., 27 S. Valley av., Vineland
Woodruff, Dare, 611 Elmer st., Vineland

HONORARY MEMBERS

Cornwell, Alfred, Bridgeton
Elmer, Matthew K., Bridgeton
Simkins, Raymond, Bridgeton

ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday of each month, October to May, inclusive. Annual Meeting is second Thursday in May.

ACTIVE MEMBERS .

Abbamonte, Louis W., 226 N. Park st., East Orange
Abel, Arthur R., Orange Memorial Hosp., Orange
Abrams, Abram B., 299 Clinton av., Newark
Adelman, Benjamin B., 186 Clinton av., Newark
Adelson, Edward T., 201 Keer av., Newark
Agnew, Hobart M., 17 Plymouth st., Montclair
Albano, Edwin H., 144 Harrison st., East Orange
Albano, Frank J., 535 N. Seventh st., Newark
Albano, Joseph, 535 N. Seventh st., Newark
Alcamo, John H., 321 S. 9th st., Newark
Alexander, John W., 308 Main st., Orange
Alexander, Walter G., 48 Webster pl., Orange
Alford, Ralph I., 83 Park st., Montclair
Allan, James S., 144 Harrison st., East Orange
Allen, Chester B., Jr., 42 Gordonhurst av., Montclair
Allen, Raymond N., 144 Harrison st., East Orange
Alling, Frederic A., 15 Washington st., Newark
Altman, Charles D., 63 Forest Hill rd., West Orange
Amato, John R., 1134 Broad st., Newark
Ambrose, Anthony, 15 Washington st., Newark
Anderson, Robert C., 686 Mt. Prospect av., Newark
Anderson, William A., 1310 Broad st., Bloomfield
Anderson, Windom E., 481 Broad st., Newark
Angelillo, Marc C., 177 Elwood av., Newark
Annunziata, Augustine, 210 Central av., Orange
Antonius, Nicholas A., 27 W. Market st., Newark
Antopol, William A., 24 Stengle av., Newark
Anuario, Charles B., 365 S. Centre st., Orange
Applebaum, Irving L., 31 Lincoln Park, Newark
Areson, Wm. H., 153 Bellevue av., Upper Montclair
Arons, Harry, 31 Lincoln Park, Newark
Ash, Samuel, 866 So. 13th st., Newark
Aszody, Paul, 340 Waverly av., Newark
Auerbach, Friedrich, 490 Stuyvesant av., Irvington
August, Jacob, 149 Rhode Island av., East Orange
Autorino, Ralph R., 10 Harrison av., Montclair
Bachmann, William, 87 Hillcrest ter., East Orange
Bacote, Ernest F., 78 Barclay st., Newark
Bagg, Linus W., Bernardsville
Baime, Jules E., 72 Prospect st., East Orange
Baiocchi, Pascal J., 203 Hunterdon st., Newark
Baker, Maclyn F., 987 Sanford av., Irvington
Balis, Samuel B., 67 Baldwin av., Newark
Balsamo, Joseph J., 224 So. Eighth st., Newark
Balson, Zachary D. B., 49 Osborne ter., Newark
Barbella, Joseph D., 498 N. 13th st., Newark
Barkhorn, Charles W., 223 Roseville av., Newark
Barkhorn, Henry C., 45 Johnson av., Newark
Barnard, Frank G., 79 Hawthorne pl., Montclair
Barrett, John E., 220 Woodside av., Newark
Barrett, Joseph F., 230 Parker av., Maplewood
Bass, Rose D., 54 Lyons av., Newark
Baum, Felix, 406 Centre st., South Orange
Baum, Lewis F., 406 Centre st., South Orange
Baum, Otto, 406 Centre st., South Orange
Baum, Samuel, 10 Osborne ter., Newark
Bauman, Everett O., 862 S. 13th st., Newark
Bauman, Rush C., 92 High st., Nutley
Becker, Martin, 66 Hawthorne av., East Orange
Becker, Marvin C., 35 Leslie st., Newark
Beer, Sanel, 184 Washington st., Norwich, Conn.
Beirne, Donald P., 52 N. Arlington av., East Orange
Beling, C. Abbott, 15 Washington st., Newark
Bell, Horace O., Essex Co. Isolation Hosp., Belleville
Belott, August V., 129 Main st., West Orange
Belott, Louis V., 529 Park av., Orange
Bender, Louis, 285 Ridgewood av., Newark
Bengelsdorf, Aron, 29 Clinton pl., Newark
Benz, George L., 32 W. Market st., Newark
Berardinelli, Carmine G., 92 Eighth av., Newark
Berg, Samuel, 156 Roseville av., Newark
Berger, William A., 346 Roseville av., Newark
Bergman, Meyer W., 31 Lincoln Park, Newark
Berlin, Morris R., 84 Girard pl., Newark
Berman, H. Robert, 299 Clinton av., Newark
Berney, Irving, 31 Lincoln Park, Newark
Berney, Ruth V., 16 Lyons av., Newark
Bernhard, William G., 174 Summit av., Summit
Bernstein, Arthur, 89 Lincoln Park, Newark
Bernstein, Julius, 584 S. Tenth st., Newark
Besson, Franklin J., 999 Clinton av., Irvington
Beyer, Othmar J., 42 Laurel av., Irvington
Bianchi, Angelo R., 184 Hunterdon st., Newark
Binder, Charles I., 833 South 13th st., Newark
Birdsall, Clarence A., 9 Smull av., Caldwell
Bissett, John V., 29 Hawthorne av., East Orange
Biunno, Anthony J., 53 Finlay pl., Newark
Blackburne, George, 490 Central av., Newark
Blasi, Benjamin, 150 Hunterdon st., Newark
Blasi, Clifford, Army
Bleiberg, Jacob, 31 Lincoln Park, Newark
Block, Charles, 368 Clinton av., Newark
Block, Marcus T., 177 Bloomfield av., Newark
Block, Max, 48 N. Fullerton av., Montclair
Block, Milton, 342 Union av., Irvington
Bocchini, Joseph A., 366 S. 12th st., Newark
Bokor, Emery, 819 S. 12th st., Newark
Bolten, Bernard, 377 Osborne ter., Newark
Bonomo, Michael J., 587 S. 10th st., Newark
Borrus, Joseph C., 3325 North 17th st., Phila. Pa.
Borsher, Irving P., 306 Ridge st., Newark
Bove, Joseph, 306 Lincoln av., Orange
Bozzi, Robert, 406 Roseville av., Newark
Brackett, Elizabeth R., 371 Franklin av., Nutley
Bradford, Stella S., 26 N. Mountain av., Montclair
Bradley, Muriel, 284 Highland av., Upper Montclair
Brady, Frank J., 1038 S. Orange av., Newark
Brady, Raymond J., 777 Clinton av., Newark
Brakeley, Elizabeth, 71 Myrtle av., Montclair
Brams, William M., 7 Madison av., Newark
Brandchaft, Bernard, 658 Springfield av., Newark
Brandman, Otto, 190 Clinton av., Newark
Braun, Gustav A., 86 Hawthorne av., East Orange
Breitstadt, Charles A., 157 Elwood av., Newark
Bremer, Kenneth M., 94 S. Munn av., East Orange
Briggs, Henry, 144 Harrison st., East Orange
Brim, Anne J. S., Edgemere Hotel, East Orange
Brizard, Joseph L., 96 N. Arlington av., East Orange
Broadnax, Mary E., 176 Eagle Rock Way, Montclair
Brodkin, Eva T., 365 Osborne ter., Newark
Brodkin, Henry A., 365 Osborne ter., Newark
Brodkin, Louis A., 365 Osborne ter., Newark
Brotman, Harry, 808 S. 11th st., Newark
Brotman, Morton M., 90 Avon av., Newark
Brown, Chester R., 22 Midland av., Arlington
Brown, Harold W., 27 S. Fullerton av., Montclair
Brown, Lewis W., 160 Roseville av., Newark
Browne, George F., 284 Highland av., UpperMontcl'r
Brunlng, Richard H., 372 Wyomlng av., Maplewood
Brunkow, Charles D., 31 Lincoln Park, Newark
Buckley, Jeremiah L., 666 Franklin av., Nutley
Buckner, Roscoe W. H., 20 Rose st., Newark
Buermann, August, III, Navy
Bull, Louis M., 92 Heller Parkway, Newark

Bull, William J., 98 Park st., Montclair
Burke, Leonard P., 30 Lakeside av., Verona
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
Burnett, Lawrence F., 386 Roseville av., Newark
Burpeau, William P., 80 Woodland av., East Orange
Burrill, Benjamin B., Jr., 83 Park st., Montclair
Burstein, Frank, 1115 S. Broad st., Newark
Burstein, Leo Q., 115 Jefferson av., Elizabeth
Burstein, Rachel, 31 Lincoln Park, Newark
Busch, Herman, 38 Johnson av., Newark
Bush, Archer C., 40 Union st., Montclair
Butan, Louis, 479 Highland av., Orange
Buvinger, Charles W., 50 Washington st., E. Orange
Byck, Louis, 794 S. 11th st., Newark
Byrnes, Elizabeth W., 160 Central av., Orange
Bythewood, Alton E., Jr., 145 W. Market st.,Newark
Cacciarelli, Robert A., 517 Roseville av., Newark
Cagan, Maclyn, 60 Ridge rd., North Arlington
Caggiano, Anthony P., 237 Grove st., Montclair
Cahill, Laurence A., 361 Lafayette st., Newark
Calasibetta, Charles J., 37 Longfellow av., Newark
Caldwell, Donald M., 132 N. Arlington av., E. Orange
Calvert, William C., 225 Gregory av., West Orange
Camche, Leo J., 250 Renner av., Newark
Cameron, Arthur E., 59 Somerset st., Newark
Cameron, Edwin A., 186 S. Burnett st., East Orange
Campbell, Everette L., 144 Harrison st., East Orange
Campbell, William, 144 Harrison st., East Orange
Cantalupo, Emidio, 95 Nichols st., Newark
Cantelmo, Alphonse L., 144 Harrison st.,EastOrange
Cappiello, William, 352 Seventh av., Newark
Caprio, Orlando G., 765 Broadway, Newark
Caputo, Anthony R., 301 Washington av., Belleville
Carbone, Francesco N., 440 Central av., Orange
Cardwell, Edgar P., 965 Broad st., Newark
Carlisle, Paul E., 763 Broad st., Newark
Carman, Fletcher F., 21 Parkway, Montclair
Carr, Josephus C., 75 13th av., Newark
Carrigan, Francis P., 305 Roseville av., Newark
Carrol, Wilfred, 51 Ingraham pl., Newark
Casale, John B., 359 Bloomfield av., Newark
Cassini, Henry C., 27 Tremont av., East Orange
Cassio, William L., 226 Norfolk st., Newark
Castellano, Martin G., 330 Roseville av., Newark
Cerone, Daniel M., 295 Roseville av., Newark
Cerreto, Frank R., 395 Roseville av., Newark
Cestone, Canio, 1425 Pompton av., Little Falls
Cetrulo, Gerald I., 234 Mt. Prospect av., Newark
Chamberlain, Richard R., 30 Lenox pl., Maplewood
Champlin, Paul M., 12 Lenox av., East Orange
Cherashore, Harry N., 363 Centre st., Nutley
Chernus, Jack, 61 Lincoln Park, Newark
Cheskin, Louis J., 31 Lincoln Park, Newark
Chiaramida, Joseph, Essex County Sana., Verona
Chiger, Alexander S., 621 High st., Newark
Chimacoff, Hyman, 159 Elizabeth av., Newark
Chmelnik, Abraham G., City Hospital, Newark
Christoph, Francis T., 959 Salem rd., Union
Ciccone, Edwin L., 261 Roseville av., Newark
Cincotti, Victor, 11 Hill st., Newark
Citrino, Robert J., 345 Centre st., Nutley
Clarken, Joseph A., 27 Ingraham pl., Newark
Clement, Baxter L., 15 Washington st., Newark
Coburn, J. Wesley, 144 Harrison st., East Orange
Coffin, Henry F., 116 N. Ninth st., Newark
Cohen, I. Elvin, 561 Elizabeth av., Newark
Cohen, Maurice, 106 Valley rd., Montclair
Cohen, Sidney L., 29 Girard pl., Newark
Cohen, Sidney P., 509 Franklin av., Nutley
Cohn, George M., 867 S. 11th st., Newark
Cohn, Hermann, 393 Clinton av., Newark
Cohn, Royal M., 740 Clinton av., Newark
Coleman, Russell M., 76 N. Clinton st., East Orange
Colmer, M. Jonas, 31 Lincoln Park, Newark
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood
Colton, Ethan T., Jr., 31 Park st., Montclair
Comando, Harry N., 695 Clinton av., Newark
Conlon, Philip J., 25 James st., Newark
Connamacher, Harold S., 671 Springfield av.,Newark
Connolly, John J., 180 Ballantine Pkwy., Newark
Connolly, Richard N., 117 Fifth st., Newark
Conti, Horace, U.S.P.H.S.
Cook, Hugh F., 21 Roseville av., Newark
Cooper, David P., 62 S. 10th st., Newark
Cooperman, William, 647 Market st., Newark
Cornish, Charles H., 673 Prospect st., Maplewood
Cortese, Joseph T., 517 Roseville av., Newark
Cott, A. Allan, 47 Lincoln Park, Newark
Coughlan, Ella A., 10 Oakwood av., Orange
Coughlin, Frank J., 100 Magnolia av., Arlington
Covino, Louis L., 44 Oakland ter., Newark
Cox, John C., 55 Woodland rd., Maplewood
Cox, William W., 79 S. Fullerton av., Montclair
Crane, Charles G., 78 Farley av., Newark
Crapanzano, Domenico, Essex Co. Hosp.,CedarGrove
Crater, Kenneth E., 24 Jersey st., Bloomfield
Crawford, Georgina U., 65 Prospect st., E. Orange
Crecca, Anthony D., 376 Roseville av., Newark
Crecca, Joseph V., 115 S. Centre st., South Orange
Crecca, William D., 111 Park av., Newark
Cregar, John S., 440 Harrison st., East Orange
Crossfield, Henry C., 144 Harrison st., East Orange
Crystell, Edward H., 4 Hawthorne av., Nutley
Culver, Perry, 53 Stratford st., W. Roxbury, Mass.
Cuono, Joseph D., Essex County Sana., Verona
Cupaiuoli, Richard A., 30 Lenox pl., Maplewood
Curtis, Elbert A., 65 Central av., Newark
D'Addario, Anthony R., 132 Broadway, Newark
D'Agostini, Alfred J., 41 Columbia av., Newark
D'Agostini, Robert J., 41 Columbia av., Newark
Dailey, Edward S., 141 Connett pl., South Orange
D'Alessandro, Arthur J., 15 Salem st., Newark
D'Ambola, Philip R., 21 S. Sixth st., Harrison
D'Amico, Thomas V., 70 Fairview av., Verona
Dane, Charles, 163 Kilburn pl., South Orange
Dane, John, 61 Scotland rd., South Orange
D'Angelo, Joseph C., 334 Washington av., Belleville
Dann, Frederick J., 65 Girard pl., Newark
Dante, Pasquale, 393 Millburn av., Millburn
Danzis, Louis, 31 Lincoln Park, Newark
Danzis, Maximillian, 31 Lincoln Park, Newark
Darby, I. Kermit, 1 Convent av., N. Y. C. 27
Darden, Walter T., 149 W. Kinney st., Newark
Davidson, Eric W., 295 Montgomery st., Bloomfield
Davidson, Maurice M., 128 Grant av., E., Roselle Pk.
Davis, Louis, 825 S. 10th st., Newark
Davis, Thomas C., 30 Old Short Hills rd., Millburn
Dear, Abraham L., 23 Synott pl., Newark
DeFilippis, Ralph L., 228 Tremont av., Orange
DeFronzo, Morando, 180 Fairmount av., Newark
DeGerome, James H., 10 Ridgewood av., Glen Ridge
Delatush, George A., 211 Park st., Montclair
Del Deo, Nicholas V., 49 State st., Newark
DeLeonardis, James V., 94 Jefferson st., Newark
Del Guercio, Olindo, 342 Clifton av., Newark
DeLia, Emilio, 25 Crane st., Newark
Della Fera, Lucien F., 206 First av., Newark
Della Ragione, Mario, 120 Second av., Newark
Del Negro, Albert E., 402 Roseville av., Newark
DeLorenzo, Francis, 281 Bellevue av., Montclair
DeMichele, Roland V., 436 Ridge st., Newark
Denes, Oscar, 402 Centre st., Nutley
Dennison, Alfred D., Jr., 601 Ridgew'd rd., Maplew'd
DePalma, Anthony F., 533 Mt. Prospect av., Newark
DePhillips, Benedict R., 228 Clifton av., Newark
DeTroia, Frederick C., 40 12th av., Newark
Deutel, Oscar R., 265 Newark av., Bloomfield
DeVincentis, Henry, 285 Henry st., Orange
Devlin, Arthur D., 138 Isabella av., Newark

Devlin, Hugh J., 72 Thomas st., Newark
deVries, John K., 144 Harrison st., East Orange
Dicker, Ralph L., 6 Clearview ter., West Orange
Dieffenbach, Richard H., 570 Mt.Prosp't av.,Newark
Diener, Samuel, 14 Clinton pl., Newark
DiFino, Felix J., 172 Edison pl., Newark
DiGiacomo, Harry E., 195 Hunterdon st., Newark
DiGiacomo, William H., 223 Fairmount av., Newark
DiLeo, Victor, 453 Park av., Orange
Dinge, Ferdinand C., 67 S. Munn av., East Orange
DiNorcia, Joseph, 498 W. Market st., Newark
Dmytriw, Stephen, 226 N. Park st., East Orange
Donchi, Sol M., 9 Madison av., Newark
Donnelly, John H., 634 S. 20th st., Newark
Dowds, Samuel C., 218 Walnut st., Montclair
Dranow, Paul, 233 Franklin av., Nutley
Drapkin, Berta, 31 Lincoln Park, Newark
Dreskin, Jacob L., 34 Lyons av., Newark
Drewniany, Bernardine, 548 Page av., Lyndhurst
DuBois, Morris G., 769 High st., Newark
Duffy, Edward P., Jr., 52 Edgewood av., Nutley
Dulany, Theodore L., 170 W. Market st., Newark
Dulin, Everett V., 144 Harrison st., East Orange
Dunn, Theodore B., 35 Park pl., Bloomfield
Durchlag, E. Nelson, 60 Myrtle av., Irvington
Dwork, Harold K., 1 Hansbury av., Newark
Ebenfeld, Samuel W., 344 High st., Newark
Echikson, Joseph I., 31 Lincoln Park, Newark
Eck, Daniel B., 144 Harrison st., East Orange
Eckhardt, Janet L., 120 Prospect st., South Orange
Edelen, James J., 100 S. Munn av., East Orange
Edelson, Edmond, 127 Lehigh av., Newark
Ehrlich, Edward, 838 S. 13th st., Newark
Ehrlich, William E., 31 Lincoln Park, Newark
Eichler, Bernard B., 221 Midland av., Montclair
Ein, William B., 31 Lincoln Park, Newark
Einhorn, Samuel E., 241 16th av., Newark
Eisenberg, David S., 31 Lincoln Park, Newark
Eisenstodt, Lester W., 31 Lincoln Park, Newark
Ellis, Arthur J., 140 Roseville av., Newark
Emerson, Linn, 303 Park av., Orange
Enimer, S. Wolfe, 31 Lincoln Park, Newark
Englander, Charles, 41 Hillside av., Newark
English, John T., 110 Yale av., Irvington
Epstein, Harry B., 31 Lincoln Park, Newark
Epstein, William M., 322 E. Westfield av., Roselle P.
Erdman, George L., 853 Chancellor av., Irvington
Erler, Robert E., 360 Prospect st., South Orange
Ervin, Millard B., 36 Canterbury lane, Westfield
Etheridge, Charles H., 433 Prospect st., East Orange
Evans, Charles H., 144 Harrison st., East Orange
Evans, David P., 144 Harrison st., East Orange
Ewing, Harvey M., 31 Trinity pl., Montclair
Fader, Ferdinand, 350 Springdale av., East Orange
Fager, Rudolph O., 53 Park pl., Bloomfield
Failing, Brayton E., 31 Lincoln Park, Newark
Fanburg, Sol J., 31 Lincoln Park, Newark
Farb, Harry H., 21 Clinton pl., Newark
Farkas, Morris, 163 High st., West Orange
Fasano, Giovanni, 194 S. Seventh st., Newark
Fava, Philip V., 355 Sanford av., Newark
Fechner, Julius, 362 Clinton av., Newark
Fein, Bernard, 585 Elizabeth av., Newark
Feinsod, Samuel N., 1305 Clinton av., Irvington
Feldman, Frank H., 115 Lyons av., Newark
Fendrick, Edward, 17 Watson av., East Orange
Ferguson, William E., City Hospital, Newark
Fern, Samuel S., 122 Elizabeth av., Newark
Feuer, Joseph A., 59 Seeley av., Arlington
Fink, A. Elston, 489 High st., Newark
Fink, Irving E., 71 Lincoln Park, Newark
Finkel, Joshua, 853 S. 11th st., Newark
Finkelstein, Abe S., 670 Clinton av., Newark
Finkler, Rita S., 35 Leslie st., Newark
Finnerty, Urban R., 71 Park st., Montclair
Fischbein, Martin M., 976 Sanford av., Irvington
Fischer, David D., 35 Goldsmith av., Newark
Fischer, Edward J., 29 Ashwood ter., West Orange
Fischer, Louise, 31 Lincoln Park, Newark
Fischman, Harold H., 326 Avon av., Newark
Fischman, Mervin, 264 Clinton pl., Newark
Flanagan, James F., 620 Summer av., Newark
Flanagan, John J., 173 Roseville av., Newark
Flax, Ira I., 890 S. 16th st., Newark
Fleischmann, Viola G., 103 Scotland rd., S. Orange
Fleming, Joseph A., 247 Claremont av., Montclair
Flicker, David J., 82 Clinton av., Newark
Floody, Robert J., 324 Kingsland st., Nutley
Flower, Morrie A., 39 Lincoln Park, Newark
Flynn, Edward A., 176 Washington av., Belleville
Foley, James F., 344 N. Grove st., East Orange
Fonda, Gerald E., 350 Millburn av., Millburn
Ford, Theodore R., 144 Harrison st., East Orange
Forte, Daniel L., 545 Central av., Orange
Forte, Frank S., 318 Roseville av., Newark
Fortunato, Joseph F., 224 Van Buren st., Newark
Fortunato, Samuel J., 90 Kenwood pl., E. Orange
Fost, William H., 107 Franklin st., Belleville
Foster, Herbert W., 2 Erwin Park, Montclair
Fowler, Royale H., 744 Broad st., Newark
Frame, Dorothy L., 15 Highland av., Glen Ridge
Francy, Donald G., 314 Stuyvesant av., Lyndhurst
Frank, Geza M., 56 Hedden ter., Newark
Frank, Simon C., 62 Ridge rd., North Arlington
Franklin, Frank A., 256 S. Centre st., Orange
Fratantuno, Michael J., 14 Vermont av., Newark
Freda, Franklin, 63 Fourth st., Newark
Freeman, George C., Prudential Ins. Co., Newark
Freeman, Richard D., 317 Carteret pl., Orange
Freinkel, Jacob, 2 Hillside av., Newark
Friedman, Harry, 721 S. 16th st., Newark
Friedman, Hyman, 744 Avenue C, Bayonne
Friedrich, Adam H., 47 Clark st., Manasquan
Fritsch, Alfred, 82 Lyons av., Newark
Froelich, Joseph C., 74 Ingraham pl., Newark
Fruchtbaum, Robert P., 431 Franklin av., Nutley
Furman, Benj. A., 31 Roseville av., Newark
Furst, Nathan J., 299 Clinton av., Newark
Furst, William, 188 Clinton av., Newark
Galioto, Frank M., 188 Ampere Parkway, Bloomfield
Gamba, Joseph, 388 Fairmount av., Newark
Gambacorta, Leopoldo, 397 N. 13th st., Newark
Gamsu, George, Army
Ganley, Arthur J., 390 Park av., East Orange
Ganot, Frank I., 392 Ridge st., Newark
Gardam, Joseph W., 16 Longfellow av., Newark
Gardner, Kenneth E., 45 Fremont st., Bloomfield
Gaydos, Albert, 225 Hillside av., Nutley
Gaylor, Earl L., Jr., 85 Harrison st., East Orange
Geannette, Ernest D., 14 Harrison av., Montclair
Gehl, Raymond H., 114 Lyons av., Newark
Gehl, Sidney H., 83 Wolcott ter., Newark
Gelb, Jerome, 86 W. Alpine st., Newark
Geller, Samuel, 696 High st., Newark
Gencher, Benjamin, 33 Park av., Caldwell
Gennell, Ernest, 298 Parker st., Newark
George, Melbourne E. W., 744 Broad st., Newark
Gerard, Patrick D., 364 Roseville av., Newark
Gerhardt, Paul E., 718 S. 17th st., Newark
Gershenfeld, David B., 73 Shanley av., Newark
Giardina, John S., 341 Walnut st., Newark
Giardina, Vincent J., 102 Jefferson st., Newark
Gibbins, A. Leslie, 60 Roseville av., Newark
Gibson, Augustus, Mendham
Giffoniello, Arthur A., 334 Roseville av., Newark
Gifford, William R., 247 Park av., East Orange
Gilbert, Samuel M., 144 Clinton av., Newark
Gillespie, John L., 26 Midland av., Arlington

Gilligan, Walter W., 164 Forest av., Glen Ridge
Gilman, Leonard, 50 Church st., Montclair
Ginsberg, Leon, Essex County Hosp., Cedar Grove
Giuffra, Frank, 161 Park st., Montclair
Giuliana, Robert A., 31 Central av., Newark
Glass, Oscar, 838 S. 12th st., Newark
Glass, William H., 144 Harrison st., East Orange
Glazier, Jesse T., 670 Sanford av., Newark
Gluckman, Saul K., 78 Johnson av., Newark
Glynn, S. Robert, 54 Girard pl., Newark
Godfrey, Alan O., 231 Roseville av., Newark
Goehring, Harrison D., 141 Central av., Montclair
Goeller, Jacob D., 1165 W. Clinton av., Irvington
Goffman, Emanuel, 316 Claremont av., Montclair
Goldberg, Bernard R., 89 Lincoln Park, Newark
Goldberg, Harold H., 814 S. 10th st., Newark
Goldberg, Louis E., 31 Lincoln Park, Newark
Goldberg, Samuel A., 169 Gregory av., W. Orange
Golden, Clement H., 347 16th av., Irvington
Goldman, Jerome, 1 Johnson av., Newark
Goldman, Lester M., 53 Leslie st., Newark
Goldmann, Joseph, 103 N. Walnut st., East Orange
Goldstein, Henry Z., 31 Lincoln Park, Newark
Goldstein, Samuel M., 40 Johnson av., Newark
Goodman, Kenneth, 141 Park av., East Orange
Gordon, A. Julius, 140 Roseville av., Newark
Gorten, Manfred L., 669 Elizabeth av., Newark
Grant, Francis, 309 Roseville av., Newark
Grant, William F., 309 Roseville av., Newark
Grasso, Anthony P., Army
Gray, John W., 142 Clinton av., Newark
Green, Henry, 89 Lincoln Park, Newark
Greenberg, Jacob L., 189 16th av., Newark
Greenberg, Samuel, 46 Johnson av., Newark
Greenfield, Bernard H., 691 Clinton av., Newark
Greenfield, Herbert, 31 Lincoln Park, Newark
Greenfield, Leonard S., 691 Clinton av., Newark
Greenfield, Sylvan J., 32 S. Munn av., East Orange
Greenwald, Eugene, 100 Hollywood av., Hillside
Greenwald, Theo. L., 44 Maple av., Morristown
Greenwood, Samuel B., 190 Clinton av., Newark
Greer, Melvin A., 190 Washington st., Bloomfield
Gregory, Mildred G., 64 N. Ninth st., Newark
Greifinger, Marcus H., 31 Lincoln Park, Newark
Greifinger, William, 22 Vassar av., Newark
Griffin, Guy B., 197 S. Centre st., Orange
Griffith, Roy, 909 Broad st., Newark
Gross, Irving, 16 Grove av., Verona
Grossblatt, Philip, 31 Lincoln Park, Newark
Gruber, William L., 680 Clinton av., Newark
Grubin, Harold, 690 Clinton av., Newark
Grundorfer, Joseph, 201 Lyons av., Newark
Gulick, James B., 363 Carteret pl., Orange
Gutowski, Walter T., 104 Grove ter., Irvington
Hahn, Katherine B., 372 Thornden st., South Orange
Hahn, William H., 198 Clinton av., Newark
Haley, Paul W., 719 Sanford av., Newark
Haller, Olga, 182 Roseville av., Newark
Halpern, William, 40 Blake rd., Brookline, Mass.
Halprin, Harry, 145 Union st., Montclair
Halsey, Levi W., 61 Church st., Montclair
Hamilton, Robert G., 92 Main st., Orange
Hanan, James T., 11 The Crescent, Montclair
Handelman, Sidney, 37 Fulton st., Newark
Hansen, Harold T., 153 Irvington av., South Orange
Hantman, Harold, 196 Roseville av., Newark
Harden, Albert S., 510 W. Market st., Newark
Harden, Albert S., Jr., 551 Ridgewood rd., Maplew'd
Harris, Jonathan L., 1060 Broad st., Newark
Harris, Leonard, 89 Lincoln Park, Newark
Harris, Morris, 102 Broad st., Bloomfield
Hartman, Winfield L., Jr., 7 Fielding court, S. Orange
Harvey, Robert K., 711 Kearny av., Arlington
Harvey, Thomas W., 59 Main st., Orange
Haschec, Walter, 690 S. 19th st., Newark
Haskin, Aaron H., 22 Goldsmith av., Newark
Hasney, Frederick A., 118 Main st., West Orange
Hauck, Lydia R. B., 644 Stuyvesant av., Irvington
Hauck, William H., 644 Stuyvesant av., Irvington
Hawkes, E. Zeh, 84 Washington st., Newark
Hawkes, Stuart Z., 84 Washington st., Newark
Hayes, Gerald W., 86 Hawthorne av., East Orange
Heineken, Theodore S., 17 Park pl., Bloomfield
Heller, Abraham R., 494 Belgrove dr., Arlington
Heller, Nathan B., 31 Lincoln Park, Newark
Hendlich, Milton G., 24 Johnson av., Newark
Henle, Carye-Belle, 202 Clinton av., Newark
Hennig, Paul F., 688 Stuyvesant av., Irvington
Henshaw, George R., 228 Midland av., Montclair
Hermann, John H., 197 S. Centre st., Orange
Herndon, Lewis S., 144 Harrison st., East Orange
Herold, Harvey T., 850 S. 13th st., Newark
Hersh, David H., 163 Huntington ter., Newark
Hertzberg, Irving, 586 Kearny av., Kearny
Hewson, George F., 21 Roseville av., Newark
Heyman, Arthur, 89 Lincoln Park, Newark
Heyman, Jacob, 846 S. 12th st., Newark
Hicks, Alfred M., Essex County Sana., Verona
Higi, Joseph E., 61 Hawthorne av., East Orange
Hill, James O., 84 Barclay st., Newark
Hill, Robert H., 227 Roseville av., Newark
Hillman, Ernest C., Jr., 300 Broadway, Newark
Hilton, Clarence O., 556 N. Seventh st., Newark
Hinckley, Livingston S., 182 Clinton av., Newark
Hirsch, Theodore, 842 S. 13th st., Newark
Hitschmann, Otto B., 97 Lincoln Park, Newark
Hobart, Richard T., 454 Park st., Upper Montclair
Holder, Lester, 1750 Walker av., Union
Holderith, Albert E., 15 Virginia av., Livingston
Holler, Henry G., 234 Montclair av., Newark
Holmes, George J., 17 Elizabeth av., Newark
Holtz, Harry M., 299 Clinton av., Newark
Hooton, Thomas C., 31 Trinity pl., Montclair
Hopping, Richard A., 15 Washington st., Newark
Horland, Aaron H., 37 Chancellor av., Newark
Horland, Ephraim, 99 Lincoln Park, Newark
Horn, Harry, 622 Stuyvesant av., Irvington
Horn, Max, 850 S. 11th st., Newark
Hosp, Paul H., 842 S. 12th st., Newark
Howard, James W., 199 Lorraine av., Up. Montclair
Howell, Thomas W., 334 Washington av., Belleville
Hubach, Maximilian F., Jr., 307 M'tg'mry st., Bimfd.
Hubbard, Robert Y., Fernwood Lodge, Hewitt
Huber, William H., 587 Prospect st., Maplewood
Huberman, John, 853 S. 12th st., Newark
Hughes, Lee W., 965 Broad st., Newark
Hulett, Albert G., 20 Hawthorne av., East Orange
Humphries, Robert E., 637 Central av., East Orange
Hurff, J. Wallace, 671 Broad st., Newark
Hyde, Robert T., Navy
Hyland, Michael, 197 Kearny av., Kearny
Hymowitz, Ben, 66 Baldwin av., Newark
Iannone, Angelo B., 659 Park av., East Orange
Iatesta, Matthew, 9 Wheeler st., West Orange
Ill, Edmund W., 477 Mt. Prospect av., Newark
Ill, Herbert M., 42 Woodland av., Glen Ridge
Inge, Hutchins F., 205 So. Orange av., Newark
Inge, Theodore R., 336 Halsted st., East Orange
Irwin, Francis T., 51 Forest av., Caldwell
Irwin, James R., 330 Washington av., Belleville
Isaac, Benoit C., 83 Central av., Orange
Israel, Joseph, 252 Washington av., Belleville
Israeloff, Howard H., 1038 Clinton av., Irvington
Jackson, George H., 100 Elmwood av., Union
Jacobs, Benjamin, 1612 Clinton pl., Hillside
Jacobs, William, 1030 Stuyvesant av., Irvington
Jaeckle, Charles E., 136 Evergreen pl., East Orange
James, Bart M., 15 Washington st., Newark
Jarvis, Daniel G., 31 Lincoln Park, Newark
Jaso, James V., 710 Varsity rd., South Orange

Jedel, Meyer, 125 4th st., Newark
Jenkins, R. Jewett, 683 High st., Newark
Jennings, Robert E., 117 Washington st., E. Orange
Jessurun, Samuel H., 613 High st., Newark
Johnson, Robert A., 68 Roseville av., Newark
Jonitz, Robert, 153 S. Grove st., East Orange
Judge, John F., 33 Hazelwood av., Newark
Just, Francis, 564 High st., Newark
Kaderabek, Erwin J., 144 Harrison st., East Orange
Kahrs, Grace M., 185 Broadway, Newark
Kalb, S. William, 416 Clinton pl., Newark
Kallen, Arnold M., 21 Leslie st., Newark
Kalter, George E., 640 Prospect st., Maplewood
Kaney, Emil M., 74 Clinton av., Newark
Kapian, Henry L., 17 Weequahic av., Newark
Katzin, Eugene M., 50 Baldwin av., Newark
Kauder, Warren G., 299 Clinton av., Newark
Kaufman, Jerome G., 299 Clinton av., Newark
Kavanaugh, Daniel E., 566 Mt. Prospect av.,Newark
Kearney, Edward P. J., 83 S. Fullerton av., Montclair
Kearney, John F., 238 Hilton av., Maplewood
Kearney, Paul A., Army
Keats, Sidney, 31 Lincoln Park, Newark
Keim, William F., Jr., 15 Washington st., Newark
Keith, Theodore R., 656 Bloomfield av., Nutley
Kelemen, Nicholas M., 315 Central av., East Newark
Kempe, George, 963 Caldwell av., Union
Kennedy, William M., VA Hospital, Livermore, Cal.
Kenney, John A., 39 Madison av., Montclair
Kern, E. Clarence, 45 Park st., Montclair
Kern, Meyer J., 144 Clinton av., Newark
Kesselman, Samuel R., 29 Stratford pl., Newark
Kessler, Henry B., 666 Clinton av., Newark
Kessler, Henry H., 53 Lincoln Park, Newark
Keyssar, Alexander, 18 Isabella av., Newark
Kiessling, Charles E., 763 Broad st., Newark
Kiley, John E., 94 Park st., Montclair
Kimche, Irwin, 37 Rawley pl., Millburn
Kimmel, Charles, 488 Broad st., Bloomfield
Kinley, John W., 111 Clinton av., Newark
Kirkby, Cyril S., 45 Woodland av., Glen Ridge
Kirkman, Leroy G., 176 Roseville av., Newark
Kirkwood, Allan S., 53 Union st., Montclair
Klein, Andrew J. V., 73 Lincoln Park, Newark
Klein, Edward C., Jr., 73 Lincoln Park, Newark
Kleinman, Maurice, 101 Clinton av., Newark
Klenk, Joseph P., 328 Belleville av., Bloomfield
Kline, George L., 423 Essex av., Bloomfield
Klosk, Emanuel, 808 S. 12th st., Newark
Klostermyer, Louis L., Mountainside Hosp., Montcl'r
Kobes, John J., 138 Kearny av., Kearny
Koch, James, 776 S. 19th st., Newark
Koeck, George P., 29 White ter., Nutley
Kohn, Leo, 86 Park pl., South Orange
Kolodin, Abraham, 98 Broad st., Bloomfield
Kornfeld, Werner, 645 Central av., East Orange
Kosterlitz, Henry H., 640 Stuyvesant av., Irvington
Kraemer, Manfred, 234 Roseville av., Newark
Kraker, David A., 31 Lincoln Park, Newark
Krichbaum, Carroll E., Army
Krone, William F., 31 Lincoln Park, Newark
Krug, Alfred J., 1460 Clinton av., Irvington
Kruger, William, 31 Lincoln Park, Newark
Kummel, Max, 31 Lincoln Park, Newark
Kunz, Harold G., 64 Hawthorne pl., Montclair
Kuperman, Henry L., 237 16th av., Newark
Kyhos, Emma D., 314 Hillside av., Nutley
Lafferty, Elton B., 69 Orange av., Irvington
Landesman, William, 187 Kearny av., Kearny
Larkey, Irving G., 95 Shanley av., Newark
Leaman, Granville M., 182 N. Grove st., E. Orange
Le Bel, Louis J. B., 165 Grant av., Nutley
Leber, Otto H., 63 Myrtle av., Montclair
Lee, John J., 309 Park av., Orange
Lee, Robert E., 24 Great Oak drive, Short Hills
Leeds, Leonard W., 701 Stuyvesant av., Irvington
Leff, Abraham, 98 Hackensack st., Wood-Ridge
Leff, Charles O., 5 Elm Court, South Orange
Leff, William A., 321 Wyoming av., South Orange
Lefkovics, Sidney C., 41 Clinton pl., Newark
Lehman, David J., Jr., 140 Roseville av., Newark
Lemkin, Samuel, 71 Pomona av., Newark
Leon, Jerome L., 89 Lincoln Park, Newark
Leon, Maurice J., 387 Up. Mountain av., Up. Montcl'r
Levin, Joseph, 831 S. 13th st., Newark
Levin, Murray, 20 Callamore dr., West Orange
Levine, Edward P., 384 Clinton av., Newark
Levine, Philip, 61 Lincoln Park, Newark
Levinson, David M., 850 S. 11th st., Newark
Levinson, Louis J., 43 S. Pierson rd., Maplewood
Levinson, Robert M., 824 S. 12th st., Newark
Levison, William, 75 Lincoln Park, Newark
Levitt, Jesse N., 26 Clinton pl., Newark
Levy, Anna L., 32 S. Munn av., East Orange
Levy, Julius, 329 Hartford rd., South Orange
Lewandowski, Edmund E., 2 Smalley ter., Irvington
Lewis, G. Rae, 458 Washington av., Belleville
Liccese, Emanuel, 84 Jefferson st., Newark
Licks, Frederick C., 64 Scotland rd., So. Orange
Lieb, Robert L., 61 Lincoln Park, Newark
Lieb, Saul, 90 Treacy av., Newark
Liegner, Ben, 858 S. 12th st., Newark
Lilien, Bernard B., 1191 Clinton av., Irvington
Lilien, Milton, 1191 Clinton av., Irvington
Lincoln, Jennings S., 140 Watchung av., Montclair
Linz, Curt, 561 Franklin av., Nutley
Lippman, Harold, 68 Elizabeth av., Newark
Lipstein, William, 845 Chancellor av., Irvington
Livingston, Bernard, 30 Park av., Caldwell
Livingston, Elias, 591 Stuyvesant av., Irvington
Livingston, Paul, 299 Main st., East Orange
Loder, Joseph S., 924 S. 17th st., Newark
Loeser, Lewis H., 188 Clinton av., Newark
Lohman, Herman, 31 Lincoln Park, Newark
Lombardo, Bartlo, 111 Wilson av., Newark
Long, John F., 82 Grand pl., Arlington
Longo, James J., 74 Ridge rd., N. Arlington
Longshore, Walter E., Jr., 216 Oakwood av., Orange
Lovell, John F., 1013 Clinton av., Irvington
Lowenstein, Aaron, 860 S. 11th st., Newark
Lowenstein, Harry A., 96 Milford av., Newark
Lowits, Otto, 78 Clinton av., Newark
Lowrey, James H., 79 Congress st., Newark
Luban, Benjamin, 730 High st., Newark
Luce, Henry A., 12 Mt. Vernon av., W. Orange
Lundblad, Walter E., 75 Prospect st., East Orange
Luongo, Federico, 212 S. Centre st., Orange
Lustig, Melvin, Beth Israel Hospital, Newark
Lutz, William M., 3 Southern Slope dr., Millburn
Lynch, Albert E. O., 257 Orange road, Montclair
Lynn, Hugh B., Pompton Turnpike, Pompton Plains
Lyon, Archibald, 115 Ridge rd., North Arlington
Lyons, James V., 333 Park av., Orange
Maas, Max A., 329 Clinton av., Newark
Mabey, J. Corwin, 242 Claremont av., Montclair
Macaluso, Dominic C., 452 Washington av.,Belleville
MacArt, J. Harold, 120 Prospect st., South Orange
MacArthur, Clymont, 219 Roseville av., Newark
Macdonald, Wentworth S., 1 N. Brookw'd dr., M'tcl'r
MacMillan, C. Wright, 4 Duryea rd., Up. Montclair
MacPherson, Elwood H., 34 Rawley pl., Millburn
Maffeo, Carl E., 149 Van Buren st., Newark
Maggio, George A., 419 Roseville av., Newark
Maggio, Nicholas A., 130 Fleming av., Newark
Magovern, Thomas F., 228 S. Orange av., S. Orange
Mahood, Herbert L., 86 Durand rd., Maplewood
Maisel, Irving, 327 Renner av., Newark
Mamlet, Alfred M., 33 Johnson av., Newark
Mancusi-Ungaro, Elviro, 155 Mt. Prospect av.,New'k

Mancusi-Ungaro, Lodovico, 156 Mt. Pr'sp't av.,Nwk.
Marcus, Donald, 987 Sanford av., Irvington
Margolis, Alfred, 736 Sanford av., Newark
Margulies, Charles, 49 Park dr., Nutley
Marin, Robert B., 85 Park st., Montclair
Marks, Zelda I., 200 Clinton av., Newark
Marquis, Dean W., 144 Harrison st., East Orange
Marquis, W. James, 12 Hawthorne av., E. Orange
Marra, Rocco S., 221 Park av., Orange
Masciocchi, Thomas A., 316 Park av., Orange
Mason, Virgil A., 144 Harrison st., East Orange
Massengill, Fulton, 233 Heywood av., Orange
Massey, J. Bruce, 665 High st., Newark
Masterson, John F., 98 Myrtle av., Irvington
Matheke, George A., 555 William st., East Orange
Matheke, Otto G., 328 Sussex av., Newark
Matheke, Otto G., Jr., 328 Sussex av., Newark
Matheson, Gilchrist E., 144 Harrison st., E. Orange
Matthews, Clifford B., 1180 Raymond Blvd., Newark
Matthews, William F., 180 Walnut st., Montclair
Mauer, Richard E., 109 S. Midland av., Arlington
Maurer, K. Virginia, 16 Prospect rd., Livingston
May, Ernst A., 157 Harrison st., East Orange
McAveney, Thos. F. G., 58 N. Munn av., East Orange
McCarroll, E. Mae, 59 Hillside pl., Newark
McCauley, Francis J., 140 Roseville av., Newark
McCormick, James E., 775 Elizabeth av., Newark
McCroskery, James H., 396 N. Arl'gt'n av.,E.Orange
McCullough, Walter A., Essex Co. Hosp., C. Grove
McGuinn, William B., 617A Central av., East Orange
McGuire, John J., 2 Gould av., Newark
McKelvey, Augustus J., 274 Millburn av., Millburn
McKeown, George H. C., 68 Mont'ne st.,Br'kl'n 2,N.Y.
McKim, William F., 317 Roseville av., Newark
McLaughlin, William B., 39 Quinby pl., W. Orange
McLellan, George A., 19 Hawthorne av.,East Orange
McNeely, Julia A., 67 S. Munn av., East Orange
McVay, Edward A., 234 Lafayette st., Newark
Medd, John C., 25 Curtis pl., Maplewood
Meehan, Martin M., 339 Washington av., Belleville
Meeker, Irving A., 581 Valley rd., Upper Montclair
Meinhard, Fred, 154 Van Buren st., Newark
Meisel, David B., 818 S. 12th st., Newark
Mele, Vincent, 268 Prospect st., South Orange
Mellen, Stanley H., 1 Park pl., Bloomfield
Menk, Paul E., 31 Lincoln Park, Newark
Merk, Anthony, 79 N. 9th st., Newark
Merkelbach, Walter P., 288 Broad st., Bloomfield
Merliss, Eugene, 386 Clinton av., Newark
Mermod, Camille, 15 Washington st., Newark
Merselis, John G., 110 Irvington av., South Orange
Messina, Thomas, 128 Park av., East Orange
Metsky, Joseph, 777 High st., Newark
Meurlin, Alfred, 144 Harrison st., East Orange
Miller, Eugene L., 63 Baldwin av., Newark
Miller, Herman P., 815 S. 12th st., Newark
Miller, I. Irwin, 675 Sanford av., Newark
Miller, Joseph A., 364 Prospect st., South Orange
Miller, Nathan, 835 S. 12th st., Newark
Miller, Ralph, 43 Girard pl., Newark
Minard, Edwy L., Knoll rd., R.F.D. No. 1, Boonton
Minier, Carl L., 226 N. Park st., East Orange
Miningham, William D., 18 Hedden ter., Newark
Minnefor, Charles A., 1164 S. Orange av., S. Orange
Mitchell, Augustus J., 270 Montclair av., Newark
Mitchell, Walter L., Jr., 161 Roseville av., Newark
Modeski, Chester J., 306 Roseville av., Newark
Moeckel, Clarence W., 63 S. Fullerton av., Montclair
Monaco, Dante P., 436 Roseville av., Newark
Monaco, Saverio A., 293 Camden st., Newark
Moncada, Salvatore, 99 Franklin st., Belleville
Monte, Thomas D., 213 Park st., Montclair
Moore, Dean C., 391 Highland av., Orange
Moress, Edward J., 1524 Maple av., Hillside
Moretti, John J., 534 S. Clinton st., East Orange
Morgan, Browne, 32 Benson st., Bloomfield
Morton, Thomas V., Jr., 263 Bloomfield av., Bl'mfield
Motzenbecker, Peter F., 680 High st., Newark
Motzenbecker, William J., 16 Milford av., Newark
Mullin, Raymond J., 76 Shanley av., Newark
Murphy, Arthur G., 454 Park st., Upper Montclair
Murphy, Thomas W., Jr., Navy
Murray, Harrold A., 624 Mt. Prospect av., Newark
Nacca, Carl A., 46 Cleveland st., Orange
Nadel, Charles I., 1013 Clinton av., Irvington
Nappi, Pasquale E., 433 Mt. Prospect av., Newark
Nash, Alexander E., 30 Forrest av., Verona
Nash, Herman S., 865 S. 11th st., Newark
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Nevius, William B., 75 Prospect st., East Orange
Newman, Grace T., 339 Grove st., Montclair
Newman, Julius, 318 Highland rd., South Orange
Ney, J. Marshall, 443 Baldwin rd., Maplewood
Nicola, Toufick, 96 Gates av., Montclair
Nimaroff, Meyer, 203 E. Wash'gt'n blvd.,Grove C.,Pa.
Noll, Louis, 1383 Clinton av., Irvington
Novich, Max, 262 Schley st., Newark
Nussbaum, Harvey E., 695 Clinton av., Newark
Nyiri, William A., 863 S. 12th st., Newark
Oberlander, Gertrude, 866 S. 13th st., Newark
O'Connor, Bernard A., 47 Central av., Newark
O'Connor, Dennis F., 27 S. Kingman rd., S. Orange
O'Connor, Michael J., 98 Shanley av., Newark
O'Connor, Paul A., 342 Roseville av., Newark
O'Crowley, Clarence R., 31 Lincoln Park, Newark
O'Grady, Michael J., 197 Nutley av., Nutley
Olini, Joseph J., 30 W. Market st., Newark
O'Lini, Louis J., 30 W. Market st., Newark
O'Neill, Charles L., 671 Broad st., Newark
O'Neill, Charles L., Jr., 671 Broad st., Newark
Onorato, Vincenzo R., 66 Christopher st., Montclair
Opdyke, Gordon M., 52 Claremont av., Verona
Openchowski, Mieczyslaw, 399 Mt. Pr'sp't av.,New'k
Oransky, Marvin, 1096 Sanford av., Irvington
Orloff, Samuel, 59 Girard pl., Newark
Ormsby, Thomas J., 1180 Raymond Blvd., Newark
Orris, Harold J., 172 Lyons av., Newark
Orton, Henry B., 224 Delavan av., Newark
Ostrowski, Sigismund J., 265 Broad st., Bloomfield
Outwin, Richard N., 29 Sommer av., Maplewood
Paddock, Royce, 965 Broad st., Newark
Palmer, Gideon H., 81 Evergreen pl., East Orange
Palmer, Henry S., 128 Court st., Newark
Panitch, William, 90 Baldwin av., Newark
Pannullo, John N. P., 266 Van Buren st., Newark
Papera, John J., 8 Washington pl., Caldwell
Parell, George C., 275 S. 7th st., Newark
Parent, Sol, 89 Lincoln Park, Newark
Parker, John E., 385 Park av., Orange
Parsonnet, Aaron E., 3 Madison av., Newark
Parsonnet, Eugene V., 89 Lincoln Park, Newark
Pascall, Thomas M., 197 Lincoln av., Newark
Pattyson, Ralph A., 144 Harrison st., East Orange
Paul, George A., 788 Lyons av., Irvington
Paul, H. Carl, 30 Westville av., Caldwell
Pavia, John R., 48 Mountainview av., East Orange
Payne, Guy, Old Stonehouse Farm, Canaan, N. Y.
Payne, Guy, Jr., 56 S. Prospect st., Verona
Pecora, Samuel, 599 Mt. Prospect av., Newark
Peer, Lyndon A., 15 Washington st., Newark
Pellecchia, Leonard J., 109 Parker st., Newark
Pelliciari, Donald, 1457 Elmwood av., Columbus, Ohio
Pendexter, Sidney E., 11 S. Arlington av., E. Orange
Pennington, Alfred W., 398 N. Maple av., E. Orange
Pentecost, Salvador D., 14 Clarem't av., Maplewood
Perham, Bertram S., 199 Lorraine av., Up. Montclair
Perlmutter, Irving K., 88 Clinton av., Newark
Permison, Michael, 1735 Stuyvesant av., Union
Perrone, Anthony J., 456 Roseville av., Newark

Petrone, Peter A., 81 Roseville av., Newark
Petry, William, 109 Treacy av., Newark
Phillips, Algernon A., 212 W. Market st., Newark
Picardi, Armand A., 256 Littleton av., Newark
Pilch, Arthur G., 1 Willard av., Bloomfield
Pilloni, Louis, 91 Beach st., Bloomfield
Pincus, Isidore, 138 Clinton av., Newark
Pinto, Joseph A., 50 N. 11th st., Newark
Pizzi, Francis W., 205 Park av., Orange
Pizzi, Mario V., 205 Park av., Orange
Pois, John, 67 Scotland rd., South Orange
Poller, Frederick K., 681 Stuyvesant av., Irvington
Pollis, Nicholas L., 642 High st., Newark
Pollock, Samuel L., 730 Prospect st., Maplewood
Polow, Benjamin, 200 Clinton av., Newark
Pomeranz, Raphael, 31 Lincoln Park, Newark
Potter, Raymond T., 144 Harrison st., East Orange
Prestifilippo, Silvestro, 105 Glenridge av., Montclair
Preston, Perry B., 12 Palm st., Newark
Price, Charles W., Essex County Hosp., Cedar Grove
Probst, Everett W., 276 Willow av., Lyndhurst
Proctor, Jesse E., 15 N. 13th st., Newark
Provenzano, Samuel, 317 S. 10th st., Newark
Quad, Clifford W., 52 Northfield av., West Orange
Quinn, Edward D., 323 Belleville av., Bloomfield
Rabinowitz, Jacob H., 35 Randolph pl., Newark
Rachlin, Harry T., 396 Union av., Irvington
Rados, Andrew, 31 Lincoln Park, Newark
Ram. Nathan H., 38 Park av., Caldwell
Rampond, James R., 579 Springdale av., E. Orange
Ranson, Briscoe B., Jr., 120 Harrison st., E. Orange
Rapalski, Adam J., Army
Rathgeber, Charles F., 18 William st., East Orange
Rattenne, Edward, 540 Mt. Prospect av., Newark
Ravitz, Samuel F., Army
Rawitz, Sidney B., 42 Chancellor av., Newark
Reeve-Allen, Jane, 42 Gordonhurst av., UpperM'tcl'r
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Reich, Emma, Essex County Sana., Verona
Reich, Henry, 89 Lincoln Park, Newark
Reich, Mortimer, 705 Elizabeth av., Newark
Reilly, Christopher J., 331 13th av., Newark
Reilly, John V., 520 Sanford av., Newark
Reinartz, Paul V., 763 Broad st., Newark
Reinfeld, Abraham G., 354 Clinton av., Newark
Reinhardt, Warren I., 276 Springdale av., E. Orange
Reissman, Erwin, 31 Lincoln Park, Newark
Remondelli, Raphael E., 216 Littleton av., Newark
Renzulli, Francesco, 228 S. Seventh st., Newark
Resch, Henry U., 185 Liberty st., Bloomfield
Restaino, Charles F., 465 Parker st., Newark
Rettig, Isidor L., 36 Milford av., Newark
Ribbans, Robert C., 63 Central av., Newark
Rich, Charles, 191 Littleton av., Newark
Rich, Wallace E., Essex County Hosp., Cedar Grove
Richardson, Marvin T., 2 E. Northfield av., Livingst'n
Richlan, Alfred, 173 Third st., Newark
Richlin, Padie, 118 Johnson av., Newark
Ricketts, Henry E., 25 Shephard av., Newark
Riffin, Irving M., 419 Park st., Upper Montclair
Rigeron, D. George, 160 Willard av., Bloomfield
Riggs, Vincent J., 295 N. Arlington av., East Orange
Rinzler, Elliot, 211 Roseville av., Newark
Ripley, E. Warren, 21 Plymouth st., Montclair
Rizzolo, Edward M., 523 Union av., Belleville
Robbin, Lewis, 18 Clinton pl., Newark
Robbins, Charles M., 31 Lincoln Park, Newark
Robbins, Eugene, 909 Broad st., Newark
Roberts, Allison H., 26 S. 9th st., Newark
Roberts, David C., 3 Glen Oaks av., Summit
Roberts, William A., 11 Park av., Caldwell
Robertson, Euston S., 500 Belgrove dr., Arlington
Robinson, Louis H., 31 Lincoln Park, Newark
Rocco, Frank, 729 Summer av., Newark
Rogers, Robert H., 49 Ninth av., Newark
Roh, Robert F., 198 Clinton av., Newark
Romano, Patrick J., 310 Central av., Orange
Rose, Salvatore J., 242 Ivy court, Orange
Roseman, Herman I., 581 Ridgewood av., Glen Ridge
Rosen, Charles D., 115 S. Munn av., East Orange
Rosen, Frank L., 33 Johnson av., Newark
Rosenbaum, Samuel X., 261 Main st., West Orange
Rosenberg, L. Charles, 11 Murray st., Newark
Rosenberg, Lillian M., 334 Bloomfield av., Montclair
Rosenberg, Max, 1585 Wyndmoor av., Hillside
Rosenthal, Arnold J., 41 Renner av., Newark
Rosenthal, Oscar J., 54 Van Ness pl., Newark
Rosenthal, Sydney, 200 Clinton av., Newark
Ross, Ira S., 188 Clinton av., Newark
Rost, Adolf S., 461 Mountainview av., Orange
Roston, Mark A., 63 Hansbury av., Newark
Roth, Ferdinand L., 98 S. Munn av., East Orange
Rothgesser, Jerome C., 14 Leslie st., Newark
Rothhouse, Burnet, 142 Hunterdon st., Newark
Rothschild, Daniel L., 31 Lincoln Park, Newark
Rothseid, Abraham, 29 Scheerer av., Newark
Rozsa, Stephen, 837 S. 11th st., Newark
Rubin, Abraham A., 240 Holmes st., Belleville
Ruccia, Arthur, 107 Clifton av., Newark
Rudomanski, Victor, 103 Duke st., Kearny
Rumage, William T., 513 Sanford av., Newark
Runyan, William J., 106 Broad st., Bloomfield
Russomanno, Paul, 212 Clifton av., Newark
Russomanno, Raymond L., 227 Clifton av., Newark
Sadusk, Joseph F., Jr., Prudential Ins. Co., Newark
Salsberg, Ralph H., 23 Johnson av., Newark
Samson, Norman D., 543 Kearny av., Kearny
Samuel, Jerome H., 61 Lincoln Park, Newark
Santora, Philip J., 361 Roseville av., Newark
Santoro, Thomas A., 141 Sanford st., East Orange
Saporito, Archibald R., 119 Ridge rd., N. Arlington
Saracino, Frank J., 107 Grand pl., Arlington
Sarno, Anthony, 130 Parker st., Newark
Saslow, Benjamin I., 102 Shanley av., Newark
Saslow, Stella K., 102 Shanley av., Newark
Sasso, Albert, 533 Mt. Prospect av., Newark
Savel, Lewis E., 73 Shanley av., Newark
Sax, Max T., Army
Sbarra, Francesco C. N., 189 Roseville av., Newark
Schaaf, Royal A., 413 Mt. Prospect av., Newark
Schaaf, Royal S., 51 Ellery st., Cambridge, Mass.
Schaffer, Barney, 10 Van Reyper pl., Belleville
Schaffer, Nathan, 172 S. Arlington av., East Orange
Schectman, Vera, 385 Osborne ter., Newark
Scheiber, Geza, 769 Kearny av., Arlington
Scheller, George A., 65 Old Short Hills rd., Millburn
Scher, Maurice A., 137 Lyons av., Newark
Schmukler, Jacob, 16 Johnson av., Newark
Schneider, Charles A., 694 Clinton av., Newark
Schneider, Louis, 874 S. 13th st., Newark
Schneider, Richard C., 874 S. 13th st., Newark
Schoenau, Carl W., 15 Highland av., Glen Ridge
Schotland, Clement E., 31 Lincoln Park, Newark
Schram, William S., 52 Liberty st., Kearny
Schramm, Joseph A., 572 High st., Newark
Schreck, Harry, 192 Roseville av., Newark
Schulsinger, Samuel, 80 Clinton av., Newark
Schulte, Herbert A., 701 Clinton av., Newark
Schults, Anna R., 25 Abington av., Newark
Schurman, Francis H. C., 35 Smull av., Caldwell
Schwartz, Harold, 200 Clinton av., Newark
Schwartz, Mortimer L., 636 Stuyvesant av.,Irvington
Schwartz, Ralph A., 675 High st., Newark
Scolamiero, Pasquale, 435 Third av., Newark
Scott, Harold R., 68 Central av., Orange
Scott, Norman M., 31 Clinton st., Newark
Scranton, Charles W., 59 Washington st., E. Orange
Seidler, Victor B., 16 Plymouth st., Montclair
Seidman, Edwin A., 580 High st., Newark

Seidman, Joshua I., Army
Seifert, Edwin A., 415 Ridgewood av., Glen Ridge
Sellitto, Anthony M., 115 Connett pl., South Orange
Sevringhaus, Elmer L., 59 Warren pl., Montclair
Seward, William H., 188 S. Essex av., Orange
Shack, Maxwell H., 19 Lyons av., Newark
Shaner, Ralph D., 94 Hillside av., Nutley
Shannon, James B., 66 S. Fullerton av., Montclair
Shannon, Lardner M., 66 S. Fullerton av., Montclair
Shapiro, Irving, 78 Clinton av., Newark
Shapiro, Louis, 146 Broad st., Newark
Shapiro, Ralph N., 668 Clinton av., Newark
Shapiro, Samuel A., 209 Avon av., Newark
Shapiro, Sydney H., 334 Union av., Irvington
Shaul, Frederick G., 10 Washington st., Bloomfield
Shaul, John F., Navy
Shaw, John J., 31 Lincoln Park, Newark
Shechner, Isadore, 244 Broadway, Newark
Sheehan, Daniel C., 535 Sanford av., Newark
Shepard, Morse A., Army
Sherman, A. Russell, 671 Broad st., Newark
Sherman, Arthur E., 70 Woodland rd., Maplewood
Sherman, Elbert S., 671 Broad st., Newark
Shill, Benjamin, 31 Lincoln Park, Newark
Shlionsky, Herman, 27 Wayland dr., Verona
Shor, David M., 32 S. Munn av., East Orange
Shreehan, Hubert F., 615 Summer av., Newark
Shulman, Murray W., 913 S. 20th st., Newark
Siegel, Jack G., 38 Johnson av., Newark
Siegel, Jacob W., 96 S. 10th st., Newark
Sieskind, Richard S., 1157 Clinton av., Irvington
Silberner, Herbert B., 99 Hillside av., Newark
Silverman, S. Andrew, 860 S. 11th st., Newark
Silverstein, Benj. J., 32 Hillside av., Newark
Silverstein, Jacob M., 73 Main st., Millburn
Simmons, Albert V., 720 Prospect st., Maplewood
Simms, George F., 541 Page av., Lyndhurst
Simon, Henry, 5 Vermont av., Newark
Simon, Ludwig L., 29 Hillside av., Newark
Simonson, Louis, 202 Osborne ter., Newark
Singer, Max, 147 Johnson av., Newark
Sisson, Nelson W., 144 Harrison st., East Orange
Siwek, Stanley, 331 Cleveland av., Harrison
Skwirsky, Joseph, 37 Randolph pl., Newark
Slavin, Paul, 31 Lincoln Park, Newark
Smalzried, Elmer W., 69 Woodland av., E. Orange
Smarzo, Marjorie M., H. S. S., Univ. of Ill., Ch'p'n.,Ill.
Smith, Charles H., 270 Ridgewood av., Glen Ridge
Smith, Christopher A., 43 Glen Ridge Pkw., Glen R.
Smith, Harold W., 179 Lincoln av., Orange
Smith, Henry G., Essex Co. Hosp., Cedar Grove
Smith, J. Meredith, 198 Valley rd., Montclair
Smith, Leonard H., 32 Washington st., East Orange
Smith, Thayer A., Forest dr., Short Hills
Snavely, Earl H., Newark City Hospital, Newark
Sobin, Julius, 190 Clinton av., Newark
Solk, Arthur G., 47 Lincoln Park, Newark
Solomon, Harold, 79 Shanley av., Newark
Somberg, Harold, 89 Lincoln Park, Newark
Somers, Fred L., 144 Harrison st., East Orange
Soschin, Samuel J., 31 Lincoln Park, Newark
Spallone, Joseph C., 123 Mt. Prospect av., Newark
Sparks, Spurgeon, Jr., 21 Oakwood av., Orange
Spence, Harold G., 205 Park st., Montclair
Sperling, Irving L., 167 Osborne ter., Newark
Sperling, Walter, 29 Oxford st., Montclair
Spinner, Samuel L., 15 Third st., Elizabeth
Sprague, Edward W., 86 Washington st., Newark
Staehle, Richard H., 366 S. Orange av., S. Orange
Stahl, Alfred, 160 Lincoln av., Newark
Stahl, Charles, 659 Sanford av., Newark
Staknevich, John H., 309 Myrtle av., Irvington
Starr, George R., Jr., Wash'gt'n av., Duxbury, Mass.
Statman, Arthur J., 17 Leslie st., Newark
Stearns, Thornton, 312 Harrison st., East Orange
Steiner, Edwin, 31 Lincoln Park, Newark
Steiner, Herbert, 350 Stuyvesant av., Irvington
Stern, David A., 127 Lyons av., Newark
Stern, Max E., 2 Milford av., Newark
Stern, Morton M., 24 Girard pl., Newark
Stevens, Merton H., 58 S. Maple av., East Orange
Stewart, Robert G., 79 Midland av., Montclair
Stickles, Lloyd C., 49 Parkhurst st., Newark
Stiles, C. Campbell, 713 Park av., East Orange
Stoddard, Gordon V., 96 Glenwood av., E. Orange
Stokes, Donald E., 120 Prospect st., South Orange
Stoll, George F., 330 Washington av., Belleville
Stoner, William H., 2 Broad st., Bloomfield
Strack, Vincent J., 1072 S. Orange av., Newark
Straub, Herbert H., 242 Springdale av., East Orange
Straus, Max, 87 Harrison pl., Irvington
Strauss, Frederick, 845 S. 12th st., Newark
Strauss, William T., Jr., 6 Jerome pl., UpperMontcl'r
Streen, Morris E., 908 Bergen st., Newark
Sturchio, Edoardo, 104 Ferry st., Newark
Sturchio, Eugenio, 178 Mt. Prospect av., Newark
Suesserman, Henry, 389 Lyons av., Newark
Sutton, Joseph G., Essex Co. Hosp., Cedar Grove
Svenson, Sven E., 515 Sanford av., Newark
Swain, Richard D., Jr., 211 Roseville av., Newark
Symes, Earl R., 544 Belgrove drive, Kearny
Szerlip, Leopold, 43 Shephard av., Newark
Szivos, Louis A., 160 Glenwood av., East Orange
Taff, Harry, 165 Roseville av., Newark
Taffet, William, 379 Union av., Belleville
Tansey, W. Austin, Jr., 169 Hobart av., Short Hills
Tarbell, Harold A., 13 Pennington st., Newark
Teeter, Charles E., 418 Orange st., Newark
Tenney, Albert S., 6 N. Munn av., East Orange
Tepper, Victor, 2 Parkview ter., Newark
Thomas, John H., 270 Lenox av., South Orange
Thomison, Harry E., 605 Broad st., Newark
Thompson, Arthur F., 314 Oakwood av., Orange
Thompson, Kenneth W., RocheOrganon, Inc., Nutley
Thomson, Carroll S., Fair Oaks Sana., Summit
Thornhill, Arthur C., 47 Forest st., Montclair
Thornley, William F., 495 Prospect st., Maplewood
Thum, Kurt W., 366 Main st., West Orange
Tillis, Herman H., 31 Lincoln Park, Newark
Tilton, William R., 763 Broad st., Newark
Tobey, Franklin J., 11 Hazelwood av., Newark
Tobey, John R., 11 Hazelwood av., Newark
Tocci, Frank, 74 Grove st., Montclair
Toczek, Heinrich A., 391 Bergen st., Newark
Tomec, Richard F., 70 Harrison av., Montclair
Torppey, John J., 472 Sanford av., Newark
Trautwein, Charles F., 131 Nesbit ter., Irvington
Travers, Frank A., 485 Park av., Orange
Troedsson, Bror S., 188 S. Essex av., Orange
Tucker, Albert B., 47 Lincoln park, Newark
Tuly, Ralph, 134 S. Kingman rd., South Orange
Tunis, Benno B., 22 Ingraham pl., Newark
Turi, Amedeo E., 407 Mt. Prospect av., Newark
Turner, Charles F., 151 Grove st., Montclair
Tushnet, Leonard, 662 18th av., Irvington
Tutela, Arthur C., 220 S. Seventh st., Newark
Twitchell, Adelbert B., 162 S. Orange av., S. Orange
Tymeson, Walter R., 310 Main st., Orange
Ulan, Oscar, 92 Fleming av., Newark
Ulvestad, Lawrence E., 119 Irvington av., S. Orange
Urbach, George, 181 Chancellor av., Newark
Valentin, Irmgard, 131 Harrison st., East Orange
Vallario, Frank A., 333 Clifton av., Newark
Vander Veer, H. Garrett, 295 M'tgomery st., Bl'mf'd
Van Emburgh, George H., 575 Belgrove dr.,Arlingt'n
Van Gieson, Edward J., 71 Watsessing av., Bloomf'ld
Vannatta, George W., 226 N. Park st., East Orange
Van Ness, H. Roy, 444 Parker st., Newark
Verbeck, Geo. B., 20 Church av., Ballston Spa, N. Y.
Villanova, Ralph N., 266 S. Eighth st., Newark

Vincent, Nicholas F., 144 Harrison st., E. Orange
Virgilio, Anthony A., 87 S. Centre st., Orange
VonHofe, Frederick H., 75 Prospect st., E. Orange
Wagner, John, 48 Wilson av., Newark
Wakeley, William E., 47 Virginia av., Livingston
Waldron, Robert E., 699 Kearny av., Arlington
Walkenberg, Michael, 56 Clinton pl., Newark
Walsh, Charles R., 95 W. Northfield av., Livingston
Walton, Ralph W., 102 Gates av., Montclair
Wangner, William F., 1190 Broad st., Bloomfield
Ward, Chauncey P., 112 Chancellor av., Newark
Ward, Elisabeth B., 555 Williams st., East Orange
Ward, Gertrude P., 41 Park pl., Bloomfield
Ward, William R., 112 Chancellor av., Newark
Ward, William R., Jr., 112 Chancellor av., Newark
Warner, Halsey F., 444 Central av., East Orange
Warner, William H. A., 444 Central av., EastOrange
Washington, William H., 321 High st., Newark
Waterman, Samuel M., 41 Shanley av., Newark
Weber, Francis C., 286 Mt. Prospect av., Newark
Weeks, Norman E., 159 Christopher st., Montclair
Weiner, Harry, 283 Franklin st., Bloomfield
Weinmann, Max H., 714 Scotland rd., Orange
Weinstein, Francis S., 857 S. 11th st., Newark
Weinstein, Leopold, 441 West End av., New York C.
Weinstein, Morris W., 942 Sanford av., Irvington
Weinstock, Michael B., 1 Johnson av., Newark
Weiss, Louis, 519 Springfield av., Newark
Weiss, Mortimer H., 78 Clinton av., Newark
Weiss, Selma, 2 Stratford pl., Newark
Weller, Arthur, 19 Hillyer st., Orange
Wesson, Harrison R., 198 Valley rd., Montclair
Weston, Clifford G., 27 Woodland av., Glen Ridge
Wheeler, William K., 140 Roseville av., Newark
Whelan, Edward P., 460 Franklin av., Nutley
White, Robert R., 144 Harrison st., East Orange
Wiener, David, 196 Weequahic av., Newark
Willan, Edward H., 74 S. Munn av., East Orange
Willey, F. Parker, 153 Roseville av., Newark
Williams, John J., 78 Walnut st., Newark
Willner, Albert, Army
Willner, Irving, 18 Waverly av., Newark
Willner, Milton, 822 S. 12th st., Newark
Willner, Philip, 852 S. 11th st., Newark
Willson, James H., 144 Harrison st., East Orange
Wilson, John H., Jr., 85 Halsted st., East Orange
Winfield, Irwin, 493 Central av., Newark
Winter, Egon W., 825 S. 10th st., Newark
Wolf, Raymond E., 251 Ridgewood av., Glen Ridge
Wolfe, Jacob S., 44 Watsessing av., Bloomfield
Wolfe, William W., 383 Mulberry st., Newark
Wood, E. LeRoy, 225 Ballantine Parkway, Newark
Woolf, Bernhardt H., 41 Hedden ter., Newark
Work, John L., Mountainside Hosp., Montclair
Wort, Frederick J., 1080 Broad st., Newark
Wortman, Herb. M., 121 Buckingh'm rd., U. Montcl'r
Wrensch, Alexander E., 79 Valley rd., Montclair
Wuerthele, Virginia E., 560 Mt. Prospect av.,Newark
Wujciak, Henry J., 193 Warwick st., Newark
Wurts, Margaret M., 27 Wellesley av., Up. Montclair
Wurzel, Milton, 2 Farley av., Newark
Wyatt, Joseph H., 135 Clinton av., Newark
Wyker, Arthur W., 57 Park pl., Bloomfield
Wynder, Alfred, 654 Lyons av., Irvington
Yablonsky, Max, 30 Shanley av., Newark
Yadkowsky, Emanuel, 637 High st., Newark
Yaguda, Asher, 61 Lincoln Park, Newark
Yates, Glen L., 270 Ridgewood av., Glen Ridge
Yelin, Gabriel, 200 Clinton av., Newark
York, Jack S., 63 Baldwin av., Newark
Young, I. Henry, 220 Columbia av., Irvington
Zacher, Andrew A., 685 High st., Newark
Zager, Saul, 40 Spruce st., Newark
Zehnder, A. Charles, 188 Roseville av., Newark
Zimmer, Louis, 184 Summit st., Newark
Zimmer, William, 1410 Maple av., Hillside
Zimmerman, Coler, 6 Colony dr., S., West Orange
Zingali, John A., 103 Glenridge av., Montclair
Zucker, Isadore, 112 Shanley av., Newark
Zukerberg, Nathan, 21 Johnson av., Newark
Zvaifler, Nathan, 46 Wilbur av., Newark
Zweibel, Leonard, 871 S. 11th st., Newark
Zweigel, Isidore, 22 Monticello av., Newark
Zybulewski, Edmund A., 410 Bergen st., Newark

ASSOCIATE MEMBERS

Alterbaum, George, 25 Park av., Caldwell
Bass, Morris, 16 Tuxedo Parkway, Newark
Becker, Sylvia F., 35 Leslie st., Newark
Bellucci, Frank D., 300 Mt. Prospect av., Newark
Bensel, Arlington, Jr., 236 Clairmont ter., Orange
Bernstein, Israel, 95 Wilson av., Newark
Bombardieri, Anthony, 251 Centre st., Nutley
Bosch, Donald T., 290 E. Franklin Tpke., Hohokus
Bromberg, Jules H., 89 Lincoln Park, Newark
Burch, Reynold E., 102 S. 14th st., Newark
Carnrick, Millard, Jr., 243 Harrison st., East Orange
Chromow, Bernard, 95 Wilson av., Newark
Cockburn, Wilfred P., 48 E. Kinney st., Newark
Comando, Edward N., 695 Clinton av., Newark
Conner, Herbert A., Bastogne A., Weeq'hic P., Nwk.
Davis, John, 10 Washington st., Bloomfield
Douglass, Frederick W., 160 Lincoln st., Montclair
Duffy, William J., 22 Nairn pl., Newark
Edwards, Sydney K., 52 Lexington dr., Livingston
Einhorn, Harvey P., 241 16th av., Newark
Evans, John R., Jr., 496 Prospect st., Maplewood
Fain, Irving, 155 Chancellor av., Newark
Fernicola, Anthony R., 565 Mt. Prospect av., Newark
Finkelstein, Aaron, 458 Hawthorne av., Newark
Finkelstein, Malvin, 2139 Boulevard, Jersey City
Gambacorta, Otto, 397 North 13th st., Newark
Gear, Phillip E., 340 Belmont av., Newark
German, Bernard, 89 Lincoln Park, Newark
Gianquinto, Peter, St. Barnabas Hospital, Newark
Goodman, Stanley J., 89 Lincoln Park, Newark
Gras, Alfred E., 160 Roseville av., Newark
Greco, Roger A., 249 North 15th st., Bloomfield
Grundfest, Jack, 659 Kearny av., Arlington
Grundfest, Philip, 53 Kearny av., Kearny
Gurian, Sydney H., 262 Seymour av., Newark
Hanfling, Seymour L., 115 S. Munn av., E. Orange
Hermann, John H., Jr., 197 South Centre st., Orange
Hill, Arthur G., 183 Grove st., Montclair
Huberman, Victor, 853 South 12th st., Newark
Insabella, John, 317 South Orange Av., Newark
Judge, Thomas V., Jr., 514 Mt. Prospect av., Newark
Kawalek, Roman, 46 So. Burnett st., East Orange
Kenny, James, 392 Tremont av., Orange
Klein, Michael, 1540 Spring Val. dr., Hunt'gt'n,W.Va.
Kollmar, Robert, Presbyterian Hosp., New York City
Koralek, Adolph H., 31 Lincoln Park, Newark
Langgaard, Charles, 517 S. Livingston av., Liv'gston
Levine, Burton, 31 Lincoln Park, Newark
Levinstone, Bertram, Army
Levy, Bernard, 181 Claremont av., Verona
Lotman, Harry, 987 Sanford av., Irvington
Marucci, Horace D., 298 Elmwood av., Maplewood
Mason, John T., Jr., 118 Young av., Cedar Grove
McCroskery, Hamilton M., 471 N. Arl'gton av.,E.O.
Merliss, Harry, 386 Clinton av., Newark
Mulberg, Harry, 769 Kearny av., Arlington
Murray, Edward F., 140 Roseville av., Newark
Nataro, Jerome D., Army
Nichols, Joseph E., 144 Harrison st., East Orange
Nimaroff, Harold, 827 South 19th st., Newark

Novak, John G., 111 Clinton av., Newark
Nutzel, Leon P., Army
Ott, Franklin B., Army
Panzer, Norman, 615 High st., Newark
Pasquale, Thomas L., 92 High st., Orange
Pedicini, Joseph L., 588 South 10th st., Newark
Pendexter, Sidney E., Jr., 11 S. Arlington av., E. Or.
Perlman, Maximilian, 188 High st., Nutley
Piegari, Felix H., 111 Mt. Pleasant av., Newark
Pilpel, Michael, 992 Fox st., New York City 59, N. Y.
Rath, Morris, 140 Fourth av., East Orange
Rich, Robert E., 191 Littleton av., Newark
Ritota, Michael C., 85 Stuyvesant av., Newark
Rotondi, Leonard J., Army
Rubin, Sidney, 170 Hawthorne av., Newark
Ruggio, Joseph, 8 Heddon ter., North Arlington
Sandford, Francis R., 30 Academy rd., Caldwell
Santangelo, Joseph A., 218 Grafton av., Newark
Sarno, John, Army
Savage, Eric D., 120 Prospect st., South Orange
Schaefer, Kenneth F., 763 Broad st., Newark
Schwartzfeld, Hyman, 301 Stuyvesant av., Newark
Shaffrey, Thomas A., 822 S. 12th st., Newark
Sheldon, Siegfried, 712 Lyons av., Irvington
Siegel, Leo, 1769 Walker av., Union
Siegel, Robert, 96 South 10th st., Newark
Simon, Franklin, 89 Lincoln Park, Newark
Sims, Eugene R., 118 N. Clinton st., East Orange
Smith, Alan L., 32 Washington st., East Orange
Sobol, Betty M., 321 Mt. Prospect av., Newark
Sobol, Herman, 205 Roseville av., Newark
Spinosa, William J., Army
Stanley, Thomas A., 77 Beech st., East Orange
Statman, Bernhardt, 849 S. 12th st., Newark
Stevens, Donald J., 42 Chancellor av., Newark
Strassburger, Paul J., Jr., 330 Wash'gt'n av.,Bellev'le
Strazza, John A., 183 Broad st., Bloomfield
Sweeley, William J., 17 Smull av., Caldwell
Szelewa, Edward S., 87 Stuyvesant av., Newark
Taffet, Seymour, 55 West Passaic av., Bloomfield
Taterka, Adrian, Lake Hiawatha
Thompson, Frank F., Jr., 261 Orange rd., Montclair
Van Amberg, Robert J., 180 Park av., Montclair
Van Ness, Walter, Jr., 89 Ampere Parkway, E. Or.
Wakeley, William E., Jr., 47 Virginia av., Livingston
Waldron, John F., 9 Mayhew dr., South Orange
Wannemacher, Paul, 173 Maple st., West Orange
Warnecke, Rudolph E., 43 S. Maple av., East Orange
Weiss, Fred, 254 Wainwright st., Newark
Weiss, William I., 80 Clinton av., Newark
Whigham, Herbert H., Jr., 38 Madison av., Montclair
Winslow, John, 210 Orange rd., Montclair
Wortman, Harry C., Jr., 17 Warren st., Nutley

EMERITUS MEMBERS

Baird, Thompson M., Point Pleasant
Baldwin, Samuel H., South Orange
Bleick, Theodore E., Newark
Chamberlain, Aims R., Maplewood
Lane, Austin W., East Orange
Lowy, Otto, Hollywood, Florida
McBride, Hesser G., East Orange
Mierau, Ernest W., West Point Pleasant
Price, Nathaniel G., Union
Smith, Byron J., East Orange
Smith, Joseph J., Newark
Young, John H., Montclair

GLOUCESTER COUNTY (8)

Society organized December, 1818. Regular meetings on third Thursday of each month, except June, July and August. Annual Meeting in May. Annual Social Session in October.

ACTIVE MEMBERS

Battaglia, Albert J., 62 Hunter st., Woodbury
Beall, William T., Main st., Clarksboro
Black, Maskell B., 128 E. High st., Glassboro
Booth, George R., 219 Highland av., Westville
Bowersox, Clarence A., 509 N. Broad st., Woodbury
Brewer, David R., Jr., 112 N. Broad st., Woodbury
Broselow, Benjamin G., Delsea dr., Franklinville
Brower, Francis M., III, 62 E. Center st., Woodbury
Bundens, Warner D., Jr., Mickleton
Burkett, J. Paul, 215 Delaware st., Woodbury
Burkett, Wendell J., 16 W. Holly av., Pitman
Campo, A. Guy, 401 Broadway, Westville
Campo, Salvatore T., 401 Broadway, Westville
Chalfant, William P., Br'dway & Crafton av.,Pitman
Chesley, Norman K., 585 Nassau av., Paulsboro
Collins, Louis K., 54 State st., Glassboro
DiMarino, Anthony J., 735 Delaware st., Paulsboro
Faux, Frederick J., 32 N. Columbia st., Woodbury
Fisler, Charles F., 140 Maple st., Clayton
Fooder, Horace M., 110 Main st., Williamstown
Harris, William G., Main st., Mullica Hill
Hollinshed, Ralph K., 351 Broadway, Westville
Hughes, Joseph F., 16 N. Broad st., Woodbury
Hunter, Harold H., 114 W. Broad st., Paulsboro
La Rosa, Frank J., 316 N. Broadway, Pitman
Laurusonis, John, 319 Broad st., Gibbstown
Lintz, Sidney Z., 525 Kings Highway, Swedesboro
Livengood, Baxter A., 64 Cooper st., Woodbury
McGuire, William A., 29 W. Wash'gton st.,Paulsboro
Moore, Ralph L., 127 N. Broad st., Woodbury
Patterson, Isaac N., 26 Station av., Westville
Pedrick, William W., 11 West st., Glassboro
Pegau, Paul M., 246 Briar Hill lane, Woodbury
Rhoads, S. Creadick, 104 Station av., Westville
Rogers, Dorothy M., 50 Cooper st., Woodbury
Ruttenberg, Louis, 19 Hopkins st., Woodbury
Serri, William S., 447 Kings Highway, Swedesboro
Sheets, Cecil C., 213 W. Broad st., Paulsboro
Sherman, Fuller G., 204 Delaware st., Woodbury
Sinexon, Henry L., 36 W. Broad st., Paulsboro
Sirotta, E. Bernard, 220 West Broad st., Paulsboro
Sooy, L. Thomas, 202 W. Holly av., Pitman
Stewart, Irving J., 529 Kings Highway, Swedesboro
Ulmer, Chester I., 431 W. Broad st., Gibbstown
Underwood, J. Harris, 509 N. Broad st., Woodbury
Wandall, Frederick G., 50 E. High st., Clayton
Weems, Don B., 105 E. Mantua av., Wenonah
Wentzell, J. Earl, 5 E. Mantua av., Wenonah
Whitaker, Henry J., 10 S. Broadway, Pitman
Wright, Herman W., 818 S. Broadway, Pitman
Zahn, Jack R., 90 Paterson av., Gibbstown
Zapf, Reville D., 100 Mantua av., Wenonah

HUDSON COUNTY (9)

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, meeting to be held on next day. Annual Meeting in May.

ACTIVE MEMBERS

Africano, Julius V., 43 Columbia ter., Weehawken
Agolia, Michael W., 2201 Palisade av., Union City
Ainsley, H. Bryson, 246 Union st., Jersey City
Albini, Mario, 204 Fifth st., Hoboken
Alpert, Edward, 661 Jersey av., Jersey City
Alter, Nicholas M., 410 Fairmount av., Jersey City
Amdur, Louis A., 2540 Boulevard, Jersey City
Angelo, Joseph A., Bank Bldg., Secaucus
Annitto, John E., 170 Belmont av., Jersey City
Anrig, Grace E., 613 Summit av., Union City
Arena, John, 9209 Boulevard, North Bergen
Aria, Charles J., 1818 Boulevard, Jersey City
Aria, Michael H., 31 Glenwood av., Jersey City
Aronoff, Herman L., 225 Claremont av., Jersey City
Aronoff, Solomon, 4000 Bergenline av., Union City
Aronowitz, Harry T., 923 Avenue C, Bayonne
Artaserse, George V., 185 Bergen av., Jersey City
Ash, Arthur F., 710 Boulevard, E., Weehawken
Auriemma, Michele, 419 Adams st., Hoboken
Aymar, Dorothy, 608 Fourth st., Union City
Bahnson, Conrad M., 170 Bowers st., Jersey City
Bailyn, Emanuel, 400 60th st., West New York
Baldini, Charles F., Jr., 513 15th st., Union City
Balsamo, Anthony J., 16 Enos pl., Jersey City
Barishaw, Samuel B., 25 Bentley av., Jersey City
Barone, Francis A., 94 Lembeck av., Jersey City
Bedrick, John J., 945 Avenue C, Bayonne
Behrens, Herman H. E., 312 Webster av., Jer. City
Ben-Asher, Solomon, 61 Gifford av., Jersey City
Benjamin, Harold C., 59 Crescent av., Jersey City
Bergen, Marshall, 100 Bentley av., Jersey City
Bergmeyer, Josef T., 6500 Palisade av., W. N. Y.
Berlin, Joseph I., 2600 Boulevard, Jersey City
Bieber, Harold B., 115 Fairview av., Jersey City
Bigliani, Urban R., 606 80th st., North Bergen
Blakey, Abram P., 157 Wegman Pkwy., Jersey City
Blum, Milton, 41 Tonnele av., Jersey City
Boland, Lucy E., 27 Washington av., Arlington
Bookrajian, Edward N., 8027 Boulevard, N. Bergen
Borchek, Arthur R., 7610 Broadway, No. Bergen
Borrone, Milton G., 2624 Boulevard, Jersey City
Borshaw, Hyman, 108 Bentley av., Jersey City
Bortone, Frank, 2765 Boulevard, Jersey City
Boselli, Emile H., 614 15th st., Union City
Botti, John A., 236 Summit av., Jersey City
Boyers, Sidney S., 413 60th st., West New York
Boylan, Matthew E., 569 Pavonia av., Jersey City
Boyle, Francis L., 805 Boulevard, Bayonne
Bradasch, George A., 1415 Central av., Union City
Brady, Thomas S., 678 Avenue C, Bayonne
Braitman, Max, 412 60th st., West New York
Brauer, Charles, 2154 Boulevard, Jersey City
Brauer, Selig L., 2012 Boulevard, Jersey City
Braunstein, Sigmund C., 424 57th st., W. New York
Braunstein, William P., 1 Bellevue st., Weehawken
Bresev, Morris, 42 Broadman Parkway, Jersey City
Brewer, Catherine H., 808 Ocean av., Jersey City
Brick, George J., 43 Cottage st., Jersey City
Brozdowski, John J., 562½ Jersey av., Jersey City
Butler, Vincent P., 33 Bentley av., Jersey City
Campana, Vincent R., 386 Fairmount av., Jersey City
Cangemi, Vito F., 50 Glenwood av., Jersey City
Cannon, Edward A., 7512 Boulevard, North Bergen
Caridi, Salvatore, 431 59th st., West New York
Carney, John W., 616 Jersey av., Jersey City
Carr, Mary B., 1 Astor pl., Jersey City
Casciano, Adolph D., 189 Harrison av., Jersey City
Catlaw, J. Kenneth, 254 Montgomery st., Jersey City
Cebula, Jerome M., 7332 Boulevard, North Bergen
Chapman, Ellis J., 203 Danforth av., Jersey City
Chapman, Walter I., 700 Avenue C, Bayonne
Chayes, Sydney, 980 Avenue C, Bayonne
Chieffo, Henry, 387 Hoboken av., Jersey City
Chizik, John J., 162 W. 31st st., Bayonne
Christian, Henry A., 111 Fairview av., Jersey City
Cieri, Daniel S., 1515 Central av., Union City
Cohen, Herman, 489 Jersey av., Jersey City
Cohen, Herman N., 108 13th st., Hoboken
Cohen, Samuel, 100 Clifton pl., Jersey City
Cohen, Samuel A., 980 Summit av., Jersey City
Comora, Herman C., 317 60th st., West New York
Connell, Emmet J., 2227 Boulevard, Jersey City
Connell, John N., 26 Carlton av., Jersey City
Connolly, Thomas W., 921 Bergen av., Jersey City
Conti, Michael, 280 Fourth st., Jersey City
Conty, Anthony J., 318 48th st., Union City
Corless, Joseph F., 5503 Palisade av., West New York
Cosgrove, Robert A., 186 Belmont av., Jersey City
Cosgrove, Samuel A., 88 Clifton pl., Jersey City
Costa, George J., 567 Jersey av., Jersey City
Coughlin, John P., 128 Wegman Pkwy., Jersey City
Cracco, Frederick A., 211 Palisade av., Union City
Cricco, Carl F., 909 Washington st., Hoboken
Crisonino, Philip D., 2815 Boulevard, Jersey City
Cufari, Carmine J., 725 18th st., Union City
Cziraky, Anton, 516 34th st., Union City
D'Acierno, Pellegrino A., 1708 Palisade av., UnionC'y
Daly, Edmund J., 921 Bergen av., Jersey City
Danielson, John J., 4703 Tonnele av., No. Bergen
DeFuccio, Charles P., 12 Duncan av., Jersey City
De Fusco, G. Thomas, 330 Newark av., Jersey City
Deitmaring, Francis A., 7922 Boulevard, N. Bergen
Del Baglivo, Mario, 266 Newark av., Jersey City
DeMarco, Silverino V., 2780 Boulevard, Jersey City
DePietro, Vincent P., 520 48th st., Union City
De Rosa, Louis, 193 Danforth av., Jersey City
Dershewitz, Irving, 835 Montgomery st., Jer. City
DeSevo, Gerard E., 108 Fairview av., Jersey City
Detrano, Salvatore J., 903 Washington st., Hoboken
DeVincenzo, F. Richard, 629 Wash'gton st.,Hobok'n
Dexter, Harriet E. T., 903 Avenue C, Bayonne
DiGioia, John, 287 Pacific av., Jersey City
Donnelly, Joseph P., 58 Kensington av., Jersey City
Donohoe, Lucius F., 140 W. Eighth st., Bayonne
Donohue, Daniel J., 139 Highland av., Jersey City
Doody, William M., 19 Bentley av., Jersey City
Doran, Ralph J., 200 11th st., Hoboken
Doran, William G., 2685 Boulevard, Jersey City
Dougherty, Daniel D., 1218 Bloomfield st., Hoboken
Driscoll, Raymond S., 117 W. Fifth st., Bayonne
Dukes, Howard R., 220 Kearny av., Kearny
Edelstein, Isidore, 938 Hudson st., Hoboken
Edwards, Lena F., 358 Pacific av., Jersey City
Elsasser, Theodore H., 7206 Park av., Woodcliff
Elwood, Benjamin J., 91 W. 38th st., Bayonne
Enright, James G., 25 Kensington av., Jersey City
Ettinger, Samuel, 501 32nd st., Union City
Evans, J. Lawrence, 7117 Park av., Woodcliff
Faber, Edward, 154 Bergen av., Jersey City
Fabriele, John B., 1112 Boulevard, Bayonne
Facciolo, Frank, 562 Boulevard, Bayonne
Faison, John B., 45 Glenwood av., Jersey City
Fattel, Henry C., 8300 Boulevard, North Bergen
Fauquier, Leonard B., 172 Jewett av., Jersey City
Federer, John J., 69 Columbia ter., Weehawken
Feinberg, Harry, 837 Avenue C, Bayonne

Feldman, Morris, 51 Bentley av., Jersey City
Felitti, Vincent J., 435 79th st., North Bergen
Feller, William, 283 Bergen av., Jersey City
Fenimore, Edward D., 77 Grace st., Jersey City
Fialk, Harry, 337 52nd st., West New York
Ficke, Sylvia A., 906 Summit av., Jersey City
Fifer, William T., 746 Avenue C, Bayonne
Figurelli, Francis A., 88 Highland av., Jersey City
Fineberg, Jacob C., 50 Glenwood av., Jersey City
Finger, Frederick A., 943 Avenue C, Bayonne
Finke, Charles H., 317 York st., Jersey City
Finke, Charles H., Jr., 317 York st., Jersey City
Finkelstein, Max, 3258 Boulevard, Jersey City
Finn, Frederick A., 921 Bergen av., Jersey City
Finn, Henry R. W., 84 Lembeck av., Jersey City
Fischer, Leo E., 70 Sherman pl., Jersey City
Flichtenfeld, Morris, 283 4th st., Jersey City
Fliegel, Hilda C., 309 Baldwin av., Jersey City
Frank, Herman I., 98 W. 35th st., Bayonne
Frank, Morris, 920 Avenue C, Bayonne
Frank, Nathan, 180 Bowers st., Jersey City
Franklin, I. Harold, 191 Palisade av., Jersey City
Freeman, Joseph, 146 W. 32nd st., Bayonne
Freymann, Walter, 5006 Hudson av., W. New York
Frieman, Hyman, 744 Avenue C, Bayonne
Frutig, Harold C., 508 80th st., North Bergen
Furman, Sol T., 344 Fairmount av., Jersey City
Gerne, Timothy A., 972 Summit av., Jersey City
Gerner, Harry E., 2627 Boulevard, Jersey City
Ghee, Euclid P., 115 Claremont av., Jersey City
Giannasio, Joseph, 10 St. Pauls av., Jersey City
Ginsberg, George, 624 Bloomfield st., Hoboken
Gleeson, William J., 640 Bergen av., Jersey City
Gnassi, Angelo M., 130 Wegman Parkway, Jer. City
Goldman, David L., 42 W. 22nd st., Bayonne
Goldsmith, Alfred S., 8129 Boulevard, North Bergen
Goldstein, Joseph D., 681 Bergen av., Jersey City
Goldstone, Karl H., 349 Edgewood av., W. Englewood
Good, Richard, 4619 Park av., Union City
Gordon, Isaac L., 1815 Boulevard, Jersey City
Gorenberg, Harold, 451 Bramhall av., Jersey City
Granelli, Humbert A., 213 Garden st., Hoboken
Greenberg, Philip, 1919 Boulevard, Jersey City
Greenberg, William B., 315 60th st., West New York
Greene, Albert D., 915 Palisade av., Union City
Greene, Harry, 90 Duncan av., Jersey City
Grieco, Emil H., 19 W. 22nd st., Bayonne
Grossman, Morris, 921 Bergen av., Jersey City
Grossman, Rubin, 377 Avenue C, Bayonne
Grubowski, Joseph N., 562½ Jersey av., Jersey City
Gurland, Benjamin B., 146 W. 37th st., Bayonne
Gurley, Katharine A., 2671 Boulevard, Jersey City
Gutmann, Erwin K., 3258 Boulevard, Jersey City
Haggerty, Francis F., 724 Hudson st., Hoboken
Hall, Perry O., 35 Bentley av., Jersey City
Halligan, Earl J., 254 Montgomery st., Jersey City
Halperin, David, 590 Bergen av., Jersey City
Halpern, Sophia L., 1311 Palisade av., Union City
Handler, Harry, 305 York st., Jersey City
Harter, Louis F., 174 Bowers st., Jersey City
Hartwell, H. Ameroy, 777 Boulevard, E., Weeh'wk'n
Harvey, John W., 818 Avenue C, Bayonne
Hasking, Arthur P., 318 Montgomery st., Jersey City
Hauptman, Harry, 88 Sherman pl., Jersey City
Heilbrunn, Julius, 2540 Boulevard, Jersey City
Hekimian, Jacob H., 2314 Palisade av., Weehawken
Hernandez, Manuel, 1974 Boulevard, Jersey City
Herradora, Juan R., 2750 Boulevard, Jersey City
Hershey, Harry H., 921 Bergen av., Jersey City
Higgins, Gerald L., 326 Lincoln av., Avon
Higgins, John T., 145 Highland av., Jersey City
Higgins, Thomas A., 2616 Boulevard, Jersey City
Hillel, Joseph, 425 77th st., North Bergen
Hirsch, Solomon, 2553 Boulevard, Jersey City
Holland, Moses H., 2412 Palisade av., Weehawken
Hollywood, James L., 219 Danforth av., Jersey City
Horowitz, Alexander S., 4614 Boulevard, Union City
Horowitz, Leo, 3644 Boulevard, Jersey City
Horowitz, Robert, 2616 Boulevard, Jersey City
Howeth, John L., 14 Duncan av., Jersey City
Huss, Louis, 4313 Bergenline av., Union City
Imhoff, John G., 913 Summit av., Jersey City
Introcaso, Dominick A., 45 Crescent av., Jersey City
Jacks, Oscar, 476 Mercer st., Jersey City
Jaffe, Benjamin, 566 Bergen av., Jersey City
Jaffe, Herman M., 2600 Boulevard, Jersey City
Jaffin, Abraham E., 41 Emory st., Jersey City
Jaksch, Maria, 137 Arlington av., Jersey City
Jaques, J. Eugenia, 74 Waverly st., Jersey City
Jensen, Grover H., 130 Jewett av., Jersey City
Jentz, John H., 67 Sherman pl., Jersey City
Johnson, Archie W., 169 Claremont av., Jersey City
Jones, Clement M., 454 Boulevard, Bayonne
Jones, J. Morgan, Valley rd., Oakland
Joseph, Benjamin M., 2771 Blvd., Jersey City
Justin, Arthur W., 41 Fulton st., Weehawken
Kainer, Herbert, 4411 Boulevard, North Bergen
Kamp, Maurice, 538 45th st., Union City
Kanengiser, Clifford H., 26 Gifford av., Jersey City
Kaplan, Herman B., 324 44th st., Union City
Katz, Jacob D., 38 Bentley av., Jersey City
Katz, Sidney, 8116 Boulevard, North Bergen
Keeney, James C., 1201 Park av., Hoboken
Keller, Rudolph J., 821 Garden st., Hoboken
Kelly, Bernard S., 1954 Boulevard, Jersey City
Kennedy, John W., 414 61st st., West New York
Kiely, Eugene M., 800 Hudson st., Hoboken
Kimmel, M. Leonard, 3342 Boulevard, Jersey City
Klein, Allan, 8628 Boulevard, North Bergen
Klein, Julius, 1513 Palisade av., Union City
Kolb, John M., 1611 Boulevard, North Bergen
Kook, Sol, 54 Grand pl., Arlington
Kooperman, Barnett, 321 60th st., West New York
Kooperstein, Samuel I., 191 Palisade av., Jersey City
Kornfield, Norman B., 24 Clinton av., Arlington
Kosminsky, Louis, 321 60th st., West New York
Kraemer, Samuel H., 309 Baldwin av., Jersey City
Kraut, Arthur M., 681 Bergen av., Jersey City
Kresch, Philip, 86 W. 34th st., Bayonne
Kuhlmann, Alvin E., 527 37th st., Union City
Kun, Bertram, 135 Belmont av., Jersey City
Kurtz, Geza R., 116 Fairview av., Jersey City
Lakiszak, Roman T., 162 Harrison av., Jersey City
Landshof, Charles A., 50 Glenwood av., Jersey City
Lane, Thomas F., 145 Garrison av., Jersey City
Lange, Louis C., 50 Clifton ter., Weehawken
Lawsing, G. Conde, 443 66th st., West New York
Lee, William A., 269 Jewett av., Jersey City
Lefkowitz, Jacob H., 445 64th st., West New York
Leir, J. Krevin, 2787 Boulevard, Jersey City
Lempke, Richard J., 3 Armstrong av., Jersey City
Lepis, A. Albert, 39 Bentley av., Jersey City
Leuzzi, Darwin A., 2515 Palisade av., Union City
Levine, G. Irving, 100 Bentley av., Jersey City
Levitov, Leo, 179 Wilkinson av., Jersey City
Lieberson, Leonard, 20 62nd st., West New York
Linden, Mortimer H., 45 Clendenny av., Jersey City
Lindroth, Lawrence V., 4525 Boulevard, N. Bergen
Lione, John G., 20 E. 32nd st., Bayonne
Lipshutz, Benjamin, 18 W. 22nd st., Bayonne
Lipshutz, Charles, 820 Avenue C, Bayonne
Lisanti, Gaetano, 6109 Monroe pl., West New York
Little, Alonzo W., 120 Arlington av., Jersey City
Litwer, Herman, 100 Bentley av., Jersey City
Lobban, Robert B., 2595 Boulevard, Jersey City
Londrigan, Joseph F., 832 Bloomfield st., Hoboken
Londrigan, Joseph F., II, 832 Bloomfield st.,Hoboken
Long, Miles T., 2150 Boulevard, Jersey City
Loori, William A., 549 Pavonia av., Jersey City
Luczynski, Edward W., 726 Avenue C, Bayonne

Lupin, Edward E., 930 Boulevard, Bayonne
Lynch, James F., 1947 Boulevard, Jersey City
Lynch, Roland J., Mental Diseases Hosp., Secaucus
Lynn, Irving I., 2760 Boulevard, Jersey City
Macchia, Benjamin J., 358 Arlington av., Jersey City
Mackin, John J., 596 Bergen av., Jersey City
Madaras, John S., 870 Avenue C, Bayonne
Madison, L. Keith, 358 Pacific av., Jersey City
Mahoney, Francis W., 41 Crescent av., Jersey City
Malinowski, John, 554½ Jersey av., Jersey City
Mandell, Sidney N., 313 Monastery pl., Jersey City
Manette, Milton, 535 41st st., Union City
Mangone, Edith, 174 Clinton av., Jersey City
Manno, Peter D., 843 Boulevard, Bayonne
Mansfield, Richard, 435 59th st., West New York
Marcus, Kurt, 85 Bowers st., Jersey City
Margolin, Samuel J., 1012 80th st., North Bergen
Markowitz, Benjamin B., 116 Gifford av., Jersey City
Markowitz, Irwin B., 2157 Boulevard, Jersey City
Marrella, Louis F., 337 Pacific av., Jersey City
Marshall, Frank A., 2202 Palisade av., Weehawken
Masiello, Carmine J., 1200 Central av., Union City
Mastromonaco, Joseph D., 790 Avenue C, Bayonne
Mathesheimer, Jacob L., 280 Old Bergen rd., Jer.C'y
Mathews, William J., 938 Hudson st., Hoboken
Matturri, Dominick A., 81 Gifford av., Jersey City
Maturi, Vincenzo E., 814 Boulevard, Bayonne
Maver, William W., 532 Bergen av., Jersey City
McCarron, James A., 727 Avenue C, Bayonne
McCarthy, John J., 1001 79th st., North Bergen
McGovern, Patrick J., 3284 Boulevard, Jersey City
McKeever, William J., 990 Summit av., Jersey City
McLean, Hugh A., 414 61st st., West New York
McLoughlin, Frank J., 558 Jersey av., Jersey City
McLoughlin, John W., 34 W. 32nd st., Bayonne
McNenney, Claudio E., 113 Fairview av., Jersey City
Meehan, George E., 117 Mercer st., Jersey City
Meltsner, Louis, 904 Hudson st., Hoboken
Meltzer, Louis, 837 Avenue C, Bayonne
Mersheimer, Christian H., 15 Reservoir av.,JerseyC'y
Meyer, William, 2128 New York av., Union City
Meyerson, Noah, 428 59th st., West New York
Mickewich, Stephen A., 817 Avenue C, Bayonne
Milanesi, Armand M., 614 79th st., North Bergen
Miller, Max H., 311 60th st., West New York
Miller, Robert B., Kings Pk. St. Hosp., Kings P.,N.Y.
Miranti, Paul J., 2685 Boulevard, Jersey City
Modarelli, Walter H., 1505 Central av., Union City
Monica, Louis A., 875 Boulevard, Bayonne
Morganstein, Louis K., 813 Avenue C, Bayonne
Moriarty, John F., 723 Washington st., Hoboken
Morley, Grace C., 1218 Hudson st., Hoboken
Morris, David G., 11 W. 26th st., Bayonne
Muccia, John J., 7 Tonnele av., Jersey City
Mueller, George H., 102 Summit av., Jersey City
Mulvihill, William J., 275 Boulevard, Bayonne
Murphy, James M., 2757 Boulevard, Jersey City
Murphy, Leo J., 1814 West st., Union City
Murphy, Patrick H. W., 27 Jefferson av., Jersey City
Murray, Joseph A., 765 Avenue C, Bayonne
Mustermann, Otto H., 303 48th st., Union City
Muttart, George W., 2521 Boulevard, Jersey City
Mutter, Alfred A., 75 Beech st., Arlington
Nafash, Shafeek, 1117 16th st., North Bergen
Neals, Huerta C., 130 Atlantic st., Jersey City
Nicholson, Frank P., 895 Summit av., Jersey City
Nobile, James J., 913 Hudson st., Hoboken
Norton, James F., 58 Kensington av., Jersey City
Norwich, Louis E., 355 Avenue C, Bayonne
Ockene, Abraham, 2415 Palisade av., Union City
O'Connor, John J., 2124 New York av., Union City
Oesterreicher, Desider, 427 Bergen av., Jersey City
O'Hanlon, George, Medical Center, Jersey City
Olpp, Arch. E., 1516 Bergenline av., Union City
Ortolano, James J., 911 Washington st., Hoboken
O'Shea, John J., 2200 Palisade av., Weehawken
Oshrin, Henry, 7500 Bergenline av., North Bergen
O'Sullivan, John R., 11 Quincy av., Arlington
Padney, Edward V., 452 Jersey av., Jersey City
Pagliughi, John J., 1915 Palisade av., Union City
Pearlstein, Frank, 325 60th st., West New York
Peckman, Abram, 2511 Boulevard, Jersey City
Penchansky, Samuel, 719 Avenue C, Bayonne
Penchansky, Samuel J., 847 Avenue C, Bayonne
Pentel, Louis S., 307 60th st., West New York
Perkel, Louis L., 2801 Boulevard, Jersey City
Perlberg, Harry J., 921 Bergen av., Jersey City
Perrone, Arthur F., 415 60th st., West New York
Peters, Edgar A. P., 394 Bergen av., Jersey City
Peterson, Charles A., 921 Washington st., Hoboken
Piltz, George F., 153 69th st., Guttenberg
Pindar, Frederick S., 7500 Park av., Woodcliff
Piskorski, Abdon V., 604 Jersey av., Jersey City
Plavin, Nathan J., 8010 Boulevard, North Bergen
Pollak, Berthold S., 100 Clifton pl., Jersey City
Pontery, Herbert B., 89 Bowers st., Jersey City
Potter, Benjamin P., 100 Clifton pl., Jersey City
Povalski, Alex. W. T., 1925 Boulevard, Jersey City
Price, H. Preston, 317 Hamilton rd., Ridgewood
Prince, Samuel, 7702 Park av., North Bergen
Purdy, Charles H., 35 Highland av., Jersey City
Pusin, Max, 88 Van Reypen st., Jersey City
Pyle, Louis A., 89 Fairview av., Jersey City
Quigley, Frederic J., 543 45th st., Union City
Raso, Frank L., 1218 Central av., Union City
Read, Donald B., 105 Hudson st., Jersey City
Reingold, Alexander, 221 Garden st., Hoboken
Reznikoff, Leon, Hudson Co. Mental Hosp.,Secaucus
Rieman, Aloysius P., 3566 Boulevard, Jersey City
Riese, Jacob A., 6012 Palisade av., West New York
Riordan, John P., 40 Midland av., Arlington
Rosen, Charles E., 321 23rd st., Union City
Rosenberg, Albert B., 120 Crescent av., Plainfield
Rosenberg, Jacob, 692 Bergen av., Jersey City
Rosenstein, Jacob L., 568 Bergen av., Jersey City
Rossi, John R., 119 W. 36th st., Bayonne
Rothberg, Moses, 438 59th st., West New York
Rubenstein Eli, 783 Avenue C, Bayonne
Rubenstein, Robert, 2758 Boulevard, Jersey City
Rubin, Bernard D., 849 Avenue C, Bayonne
Ruffer, Ralph A., 619 15th st., Union City
Rundlett, Emilie V., 79 Prospect st., Jersey City
Ruoff, Andrew C., 2414 New York av., Union City
Russillo, Philip, 155 Clerk st., Jersey City
Ruvane, Joseph J., 2787 Boulevard, Jersey City
Sabini, Cecil F., 603 Jefferson st., Hoboken
Sacco, Anthony G., 2200 New York av., Union City
Sachs, Fred, 48 Warner av., Jersey City
Sachs, Wilbert, 921 Bergen av., Jersey City
Sager, Harold, 19 W. 22nd st., Bayonne
Sakowski, John P., 20 W. 22nd st., Bayonne
Saladino, Anthony J., 427 15th st., Union City
Salmon, Edward F., 50 Gifford av., Jersey City
Salzmann, Bertold, Margaret Hague Hosp., Jer. City
Saradarian, Albert V., 2401 New York av., Union City
Santangelo, Stephen, 461 Jersey av., Jersey City
Schapiro, Morris, 800 Avenue C, Bayonne
Schenker, Benjamin N., 246 Fifth st., Jersey City
Schenker, Israel N., 3697 Boulevard, Jersey City
Schenker, Sarah S., 1009 Garden st., Hoboken
Schept, Samuel S., 523 37th st., Union City
Schimenti, Matteo, 1883 Boulevard, Jersey City
Schlein, August, 707 Park av., Hoboken
Schneckendorf, Samuel J., 179 Harrison av., Jer.City
Schneider, Harry M., 89 Gifford av., Jersey City
Schneider, Louis A., 412 61st st., West New York
Schorr, Herman E., 26 Lincoln Parkway, Bayonne
Schuchner, William F., 550½ Jersey av., Jersey City
Schuck, Traugott J., 58 Ninth st., Hoboken
Schwab, George P., 7914 Boulevard, North Bergen

Schwartz, Frank, 513 Boulevard, Bayonne
Schwartz, Harold B., 47 Duncan av., Jersey City
Schwartz, Lewis, 2695 Boulevard, Jersey City
Schwarz, Berthold T. D., 2787 Boulevard, Jersey City
Schwarz, Henry J., 8534 Boulevard, North Bergen
Schwarz, John, 50 Hauxhurst av., Weehawken
Sciarrillo, Louis F., 105 Newark st., Hoboken
Sciorsci, Edward F., 609 Bloomfield st., Hoboken
Sciorsci, Mario, 609 Bloomfield st., Hoboken
Scott, John J., 6 Zerman pl., Weehawken
Scott, Samuel G., 141 Bergen av., Jersey City
Seligmann, Fred S., 501 32nd st., Union City
Shapiro, Edward E., 750 Avenue C, Bayonne
Shapiro, Nathaniel J., 212 Palisade av., Union City
Sheer, Harold, 19 W. 22nd st., Bayonne
Sheeran, Vincent J., 101 Bentley av., Jersey City
Shepard, Myron, 435 60th st., West New York
Sherman, Abraham, 68 Clifton ter., Weehawken
Shipman, Robert T., 904 Summit av., Jersey City
Shook, Benjamin E., 284 Bergen av., Jersey City
Shulman, Nathan L., 538 45th st., Union City
Siegel, Lester, 180 Belmont av., Jersey City
Siegler, Julius, 646 Bergen av., Jersey City
Sigman, George, 254 Union st., Jersey City
Silich, Robert L., 875 Boulevard, E., Weehawken
Silon, Milton R., 907 Washington st., Hoboken
Silvera, Salomon, 532 Bergen av., Jersey City
Simeone, Peter A., 138 Clerk st., Jersey City
Simpson, David B., 9 East 35th st., Bayonne
Singer, Sina S., 3443 Boulevard, Jersey City
Sinnott, Gerald W., Medical Center, Jersey City
Skrypski, Joseph M., 2756 Boulevard, Jersey City
Smith, Meyer, 14 Webster av., Jersey City
Snyder, W. Jay, 74 Columbia ter., Weehawken
Solomon, Louis, 7 Tonnele av., Jersey City
Sottilaro, Joseph J., 1921 Boulevard, Jersey City
Spano, Frank, 320 47th st., Union City
Spath, William H., 722 Hudson st., Hoboken
Spohn, Eugene L., Box 61, Fort Whipple, Ariz.
Starr, Benjamin, 70 Sherman pl., Jersey City
Starr, Eli, 16 62nd st., West New York
Statile, Pasquale A., 598 Pavonia av., Jersey City
Stefansin, Frank, 1601 Boulevard, North Bergen
Stein, Albert, 600 80th st., North Bergen
Stein, Jacob M., 68 Columbia ter., Weehawken
Stockfisch, Robert H., 3637 Boulevard, Jersey City
Stokes, Anthony T., 819 First st., Secaucus
Stuart, William C., 1 Newark st., Hoboken
Sussman, Harold, 103 10th st., Hoboken
Swiney, Juliana C., 325 Avenue C, Bayonne
Swiney, Merrill A., III, 325 Avenue C, Bayonne
Taft, Herman L., 4401 Boulevard, North Bergen
Talty, John C., 935 Washington st., Hoboken
Tannert, Carl H., 331 77th st., North Bergen
Tataryan, Hovsep, 2024 New York av., Union City
Temes, J. Howard, 9 Garrison av., Jersey City
Terwedow, Henry, 7707 Boulevard, North Bergen
Terwedow, Walter G., 518 79th st., North Bergen
Thomas, Ralph B., 793 Montgomery st., Jersey City
Tidwell, Harold F., 6101 Boulevard, E., W. New York
Tomaiuoli, Michele, 19 76th st., North Bergen
Trewhella, Arthur P., 376 Fairmount av., Jersey City
Troum, Nathan, 82 Danforth av., Jersey City
Tsucalas, James C., 29 Highland av., Jersey City
Tyndall, Hugh H., 83 Highwood ter., Weehawken
Urevitz, Abraham, 2415 New York av., Union City
Utkewicz, Edmond A., 2633 Boulevard, Jersey City
Varriano, John L., 3263 Boulevard, Jersey City
Vespignani, Pasquale, 863 Montgomery st., Jer. City
Visceglia, Frank R., 430 74th st., North Bergen
Visconti, Joseph A., 105 Newark st., Hoboken
Viti, Henry A., 274 Barrow st., Jersey City
Vostrosablin, Nicholas A., 121 Grand st., Jersey City
Wager, Henry P., 39 Gifford av., Jersey City
Wallack, Eli A., 92 Fairview av., Jersey City
Waters, Edward G., 39 Gifford av., Jersey City
Watman, Anthony J., 2784 Boulevard, Jersey City
Weber, Laura E., 305 23rd st., Union City
Weber, Walter D., 305 23rd st., Union City
Weisman, Herbert, 273 Avenue A, Bayonne
Weiss, Morris J., 734 Avenue C, Bayonne
Weston, Elaine, 40 Midland av., Arlington
Wheeler, James A. V., 85 VanReypen st., JerseyCity
White, Hugh M., 901 Summit av., Jersey City
White, Thomas J., 50 Glenwood av., Jersey City
Wichman, Heins, 2672 Boulevard, Jersey City
Wilcox, Frank A., 329 60th st., West New York
Woltz, Sidney, 2206 New York av., Union City
Yanowitz, Bernard, 135 Bergen av., Jersey City
Yeaton, William L., Jr., 204 11th st., Hoboken
Yontef, Reuben, 851 Avenue C, Bayonne
Yudkoff, William, 770 Avenue A, Bayonne
Zampella, Arthur, 921 Bergen av., Jersey City
Zbar, Joseph E., 2690 Boulevard, Jersey City
Zitani, Alfred M., 937 Washington st., Hoboken
Zuckerberg, Irving, 800 Avenue C, Bayonne

HONORARY MEMBERS

Atwell, David R., Hoboken
Connell, John, Jersey City
Gille, Hugo, Jersey City
Older, Benjamin, St. Petersburg, Florida
Pyle, Wallace, Jersey City
Rosecrans, James H., Hoboken
Selinger, Samuel, Lake Worth, Florida
Sexsmith, George H., Los Angeles, California
Stout, J. Phillip, Jersey City
Woelfle, Henry E., West Palm Beach, Florida

HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets on fourth Tuesday of January, April, July, and October, April being the Annual Meeting.

ACTIVE MEMBERS

Baker, Philip W., High Bridge
Bambara, Aurelius J., Flemington
Beatty, Hannah J., Clinton Farms, Clinton
Boyer, Charles G., Annandale
Clark, Frank G., White House Station
Coleman, Austin H., Clinton
Crooks, William J., III, Clinton
Ctibor, Vladimir F., Califon
Dantzig, Henry, 12 S. Franklin st., Lambertville
Davidson, Henry A., R. D. 2, Flemington
Decker, Frederick H., Frenchtown
English, Samuel B., N. J. State Hosp., Glen Gardner
Felder, Samuel, 221 Main st., Flemington
Fluck, Paul H., 73 N. Union st., Lambertville
Fritz, John F., Jr., 95 Main st., Flemington
Fuhrmann, Barclay S., 10 Main st., Flemington

Fuhrmann, John B., 10 Main st., Flemington
Germain, Raymond J., Clinton
Hamilton, Lloyd A., 46 York st., Lambertville
Harps, James A., 72 Center st., Clinton
Henry, George, 33 Mine st., Flemington
Jenkins, Arthur M., 701 Harrison st., Frenchtown
Knox, Howard A., New Hampton
Lane, Edgar W., 46 Main st., Bloomsbury
Leaver, Morris H., Quakertown
Merrill, Edwin D., R. D. No. 1, Titusville
Simon, Fritz C., Hampton
Tompkins, Grenelle B., 52 Broad st., Flemington

MERCER COUNTY (11)

Society organized May 23, 1848. Meets on second Wednesday of each month except July, August, and September, at 9:00 p. m., in the State Society Headquarters, Trenton. Annual Meeting in December. Annual Banquet in November.

ACTIVE MEMBERS

Abey, William J. H., 65 S. Main st., Pennington
Abrams, Henry, 195 Nassau st., Princeton
Ackley, David B., 21 N. Clinton av., Trenton
Albert, Perry, 2780 S. Broad st., Trenton
Anthony, David W., 201 Witherspoon st., Princeton
Apple, Stanley B., 1520 Brunswick av., Trenton
Applestein, Robert, 568 E. State st., Trenton
Aronis, Harry R., 935 W. State st., Trenton
Ashley, Harmon H., 20 Nassau st., Princeton
Austin, Henry J., 96 Bellevue av., Trenton
Barlow, John D., 232 Stockton st., Hightstown
Barry, R. Grant, 908 W. State st., Trenton
Bayne, Joseph K., Army
Beairsto, Everett B., 224 W. State st., Trenton
Belfer, Jacob J., 1235 Chambers st., Trenton
Belford, Ralph J., 90 Nassau st., Princeton
Bellis, Horace D., 437 E. State st., Trenton
Berman, Jacob J., 409 Market st., Trenton
Bernstein, Bertram, 35 Boudinot st., Trenton
Berry, Leonard M., 205 Nassau st., Princeton
Bird, Ivan F., N. J. State Hospital, Trenton
Blackwell, Enoch, 28 W. State st., Trenton
Blaugrund, Samuel, 833 W. State st., Trenton
Bonnet, W. Laurence, 2791Not'gham way,Mercerv'le
Borrella, Dominic D., 476 Hamilton av., Trenton
Burbidge, J. Raymond, 10 Bayard lane, Princeton
Burns, Joseph R., 254 S. Olden av., Trenton
Burroughs, Edmund W., 701 W. State st., Trenton
Byer, M. Yale, 442 Greenwood av., Trenton
Carabelli, A. Albert, 306 Hamilton av., Trenton
Carroll, C. Walter, 125 Centre st., Trenton
Carroll, William V., 211 Academy st., Trenton
Cella, Charles F., 359 Hamilton av., Trenton
Chandler, Swithin, Jr., 4273 S. Broad st., Yardville
Charleroy, Durant K., 935 Greenwood av., Trenton
Chesner, William A., 1111 Hamilton av., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton
Clark, Alice L., 206 W. State st., Trenton
Clement, John B., 178 W. State st., Trenton
Clunan, Ambrose P., 851 Hamilton av., Trenton
Cohan, Charles C., 217 W. Hanover st., Trenton
Cohan, Joseph, 217 W. Hanover st., Trenton
Cohen, Herman, 1301 Hamilton av., Trenton
Cohen, William, 1007 Greenwood av., Trenton
Colavita, James J., 433 Princeton av., Trenton
Comfort, John B., 50 S. Clinton av., Trenton
Commini, Frank F., 439 Bellevue av., Trenton
Conte, Andrew N., 1018 S. Broad st., Trenton
Corio, George A., 307 S. Clinton av., Trenton
Corrigan, Patrick H., 1720 S. Broad st., Trenton
Cotton, Henry A., Jr., Dept. Inst. and Agenc's, Tr'nt'n
Cottone, R. John, 683 Princeton av., Trenton
Cowlbeck, H. Donald, 224 W. State st., Trenton
Cox, Harold C., 208 Stockton st., Hightstown
Davenport, Irwin P., 545 W. State st., Trenton
Davis, Harold L., 178 W. State st., Trenton
Davis, John E., Jr., 211 Linden st., Riverton
Davison, Royden W., Hotel Hildebrecht, Trenton
Dean, Guy K., Jr., Princeton rd., Plainsboro
Deitz, Joseph R., 320 Centre st., Trenton
Denelsbeck, J. Otis, 878 E. State st., Trenton
Dimun, John T., 1000 S. Broad st., Trenton
Dodge, James T., 1819 S. Broad st., Trenton
Doranz, Harold K., 502 W. State st., Trenton
Drezner, Henry L., 216 W. State st., Trenton
Eames, William N., 1871 Pennington rd., Trenton
Eckstein, David, 407 Greenwood av., Trenton
Edwards, Walter R., 2624 Quaker Br. rd., Mercerville
Elias, Elmer J., 474 Greenwood av., Trenton
Ellis, Ralph W., 64 Fairview av., Morrisville
Engelhart, Ferdinand K., 28 Oak lane, Trenton
English, Harrison F., III, 160 W. State st., Trenton
Ernest, Richard B., 240 W. State st., Trenton
Fabian, Paul L., 520 Princeton av., Trenton
Farmer, Walter D., 28 S. Main st., Allentown
Fessler, A. James, 1544 S. Broad st., Trenton
Fine, Sydney G., 868 Stuyvesant av., Trenton
Finegan, Paul J., 200 W. State st., Trenton
Finkle, Lester J., 225 Perry st., Trenton
Fiorello, Joseph R., 689 Princeton av., Trenton
Fluck, David A., 626 W. State st., Trenton
Forer, Robert, 227 Centre st., Trenton
Franzoni, Andrew E., 938 Brunswick av., Trenton
Friedman, Max, 849 W. State st., Trenton
Friedman, Meyer H., 949 W. State st., Trenton
Friedmann, Leonard L., 484 Princeton av., Trenton
Frisch, Felix, 726 W. State st., Trenton
Fuchs, Jacob N., 1267 S. Broad st., Trenton
Garber, Robert S., N. J. State Hospital, Trenton
Garfinkel, Abraham, 1801 Greenwood av., Trenton
Garwood, Norman W., Main st., Crosswicks
Gindhart, Floyd D., 1233 Hamilton av., Trenton
Gindhart, John H., 1233 Hamilton av., Trenton
Goldberg, Benjamin M., 1156 E. State st., Trenton
Goldman, Leo L., 325 Market st., Trenton
Goyne, James B., 2785 Main st., Lawrenceville
Graham, Ernest E., 66 Clark av., Somerville
Granger, James R., 235 Spring st., Trenton
Gribbin, James A., 836 W. State st., Trenton
Guglielmelli, Angelo D., 449 Hamilton av., Trenton
Hafetz, M. Morris, 114 Centre st., Trenton
Haggerty, D. Leo, 227 N. Warren st., Trenton
Hammell, Frank M., 137 S. Main st., Allentown
Haney, John J., 850 Hamilton av., Trenton
Harman, J. Reginald, 824 W. State st., Trenton
Hess, George A., Titusville
Hiden, Joseph C., 199 Nassau st., Princeton
Hirschfield, Bernard A., 514 Greenwood av., Trenton
Hofbauer, Ernest, 695 Parkway av., Trenton
Horhovitz, George I., 324 S. Broad st., Trenton
Hunter, Floyd D., 3620 Nottingh'm way,HamiltonSq.
Hutchinson, A. Dunbar, 913 W. State st., Trenton
Hutchinson, Geo. F., 55 Mercer st., Hamilton Square
Ivins, William C., 455 W. State st., Trenton
Jaspan, Samuel C., 820 Division st., Trenton
Johnson, John F., 926 W. State st., Trenton

Kachdorian, Vartan, 935 Brunswick av., Trenton
Kaplan, Harry, 186 W. State st., Trenton
Kehler, James G., Jr., 104 Perry st., Trenton
Kinczel, John A., 971 S. Broad st., Trenton
Klempner, Paul, 637 Greenwood av., Trenton
Kline, Joseph J., 733 Hamilton av., Trenton
Knauer, Charles H., Jr., 214 W. State st., Trenton
Kohn, Joseph J., 201 Broad St. Bank Bldg., Trenton
Kohn, Ralph B., 201 Broad St. Bank Bldg., Trenton
Kondor, Joseph S., 978 S. Broad st., Trenton
Koplin, Nathaniel H., 142 W. State st., Trenton
Kren, Frank, 718 W. State st., Trenton
Kustrup, John F., 1418 S. Broad st., Trenton
Lapin, Louis P., 15 Crosswicks st., Bordentown
Lapin, Mathew R., 628 W. State st., Trenton
Larkin, Michael J., 705 Hamilton av., Trenton
Larsson, Evert A., N. J. State Hospital, Trenton
Laufenberg, Joseph W., 1544 S. Broad st., Trenton
Lavine, Barney D., 630 N. Clinton av., Trenton
Lavine, Sidney B., 144 W. State st., Trenton
Ledden, Lewis J., 1104 Hamilton av., Trenton
Leshin, Harry, 564 S. Main st., Hightstown
Lettiere, Anthony J., 425 E. State st., Trenton
Levy, Irvin, 222 W. State st., Trenton
Lewis, Sydney B., 194 W. State st., Trenton
Light, Arthur B., Lawr'ceville Sch'l, Lawrenceville
Little, William R., 493 W. State st., Trenton
Lloyd, Samuel J., 178 W. State st., Trenton
Lynch, Donald C., 885 Stuyvesant av., Trenton
MacDermid, Lynden E., 506 Farnsw'th av.,Bordent'n
Magee, Harold S., N. J. State Hospital, Trenton
Magson, Albert E., 302 S. Main st., Hightstown
Mains, M. Paul, Mercer Hospital, Trenton
Majeski, Henry J., 930 Brunswick av., Trenton
McCarthy, William P., 1203 Parkside av., Trenton
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Means, Paul B., N. J. State Hospital, Trenton
Miller, Earle K., 2502 Nottingham way, Trenton
Miller, Gerald H., N. Main st., Cranbury
Miller, Raymond E., 192 W. State st., Trenton
Miller, Reginald C., 1420 Greenwood av., Trenton
Miller, Samuel R., 407 S. Main st., Pennington
Minschwaner, Geo. G., Jr., 832 Greenw'd av.,Trenton
Mitchell, Charles H., 1100 W. State st., Trenton
Mitskas, Theo. V. J., 1329 Greenwood av., Trenton
Moore, J. Leonard, 59 Westcott rd., Princeton
Moriconi, Albert F., 438 Hamilton av., Trenton
Mountford, William E., 215 N. Warren st., Trenton
Munro, Jeannette, 2 Queenston pl., Princeton
Murphy, James A., 312 Bellevue av., Trenton
Murto, Thomas V., 117 Buckingham av., Trenton
Nayfield, Ronald C., 974 S. Broad st., Trenton
Nonziato, Frank A., 50 Centre st., Trenton
Ogden, Andrew E., 1829 Greenwood av., Trenton
O'Neill, Joseph F., 41 E. Broad st., Hopewell
O'Rourke, James J., 871 Stuyvesant av., Trenton
Pantaleone, Joseph, 504 Hamilton av., Trenton
Parker, Paul, 72 N. Clinton av., Trenton
Pepe, Salvatore A., 638 Perry st., Trenton
Pessel, Johannes F., 224 W. State st., Trenton
Peterson, Walter R., 312 W. State st., Trenton
Pierson, Carl L., 395 W. State st., Trenton
Pierson, Joseph R., 10 E. Broad st., Hopewell
Pinerman, Robert B., 308 W. State st., Trenton
Pittman, Allen R., N. J. State Hospital, Trenton
Pollard, William E., 194 Nassau st., Princeton
Potter, Ellen C., 301 W. State st., Trenton
Powis, Ethel M., 845 W. State st., Trenton
Poyas, Morton L., 730 W. State st., Trenton
Preece, John D., 192 W. State st., Trenton
Proctor, Francis E., 332 W. State st., Trenton
Prunetti, Carmen, 311 Chestnut av., Trenton
Purcell, Ernest F., 800 Stuyvesant av., Trenton
Quackenbos, Harrie M., N. J. State Hospital, Trenton
Ragany, Joseph, Veterans Facility, Wilm'gt'n, Del.
Rainey, Willard G., 34 Bayard lane, Princeton
Rampona, Joseph M., 272 Nassau st., Princeton
Rathauser, Frank, 399 W. State st., Trenton
Rathmell, Thomas K., Mercer Hospital, Trenton
Reisinger, Paul B., 369 W. State st., Trenton
Resnick, Nathan, 205 Market st., Trenton
Rita, James J., 235 S. Clinton av., Trenton
Robinson, Aaron J., 635 S. Warren st., Trenton
Rogers, Laurence H., Donnelly Mem. Hosp., Trenton
Rose, William G., 232 Stockton st., Hightstown
Rothman, Sidney, 870 Stuyvesant av., Trenton
Rowan, Henry M., 224 W. State st., Trenton
Sackin, Stanley, 834 W. State st., Trenton
Salvatore, Joseph T., 324 Hamilton av., Trenton
Salway, Benjamin, 321 S. Broad st., Trenton
Scasserra, Benedict B., 163 Nassau st., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Seely, Roy B., 104 N. Clinton av., Trenton
Seitzick-Robbins, H. E., 723 W. State st., Trenton
Sekerak, Albert J., 984 S. Broad st., Trenton
Sharbaugh, George B., 212 W. State st., Trenton
Shear, M. Murray, 1158 E. State st., Trenton
Sica, L. Samuel, 431 E. State st., Trenton
Siemion, Theophilis R., 1005 Brunsw'k av., Trenton
Sill, John B., Black Rock rd., Yardley, Pa.
Silver, E. Drew, 136 Stockton st., Hightstown
Slack, Clarence J., 230 W. State st., Trenton
Smith B. Earl, 1017 Greenwood av., Trenton
Smith, DeWitt H., 194 Nassau st., Princeton
Smith, Frank W., 1238 S. Clinton av., Trenton
Smith, Percy L., West Afton av., Yardley, Pa.
Snegireff, Leonid S., 540 Parkway av., Trenton
Sollami, William R., 2331 S. Broad st., Trenton
Sommer, George N. J., 120 W. State st., Trenton
Sommer, George N. J., Jr., 120 W. State st., Trenton
Spradley, Jeems B., N. J. State Hospital, Trenton
Stabile, John A., Grand av., West Trenton
Stein, Louis A., 226 W. State st., Trenton
Storaci, Frank S., 715 Hamilton av., Trenton
Straus, Walter, 1239 Greenwood av., Trenton
Sullivan, James M., III, 88 Spring st., Trenton
Summers, Alfred D., 71 Palmer sq., Princeton
Sutnick, Theodore B., 25 Richey pl., Trenton
Swern, Nathan, 399 W. State st., Trenton
Taylor, Earl S., 2 Elm rd., Princeton
Taylor, John H., N. J. State Hospital, Trenton
Tenney, Luman H., 177 Prospect st., Princeton
Thurm, Arthur S., 225 W. State st., Trenton
Tomec, Otto C., 756 Parkway av., Trenton
Treiber, Benjamin A., 219 W. State st., Trenton
Tretter, Hans L., 501 W. State st., Trenton
Turner, Rodney C., 609 Greenwood av., Trenton
Urbaniak, Henry S., 883 Brunswick av., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
Vanneman, Joseph S., 45 Princeton av., Princeton
Vento, Sebastian J., 452 Hamilton av., Trenton
Vine, Blair, 662 Stuyvesant av., Trenton
Vol-Tretter, Marta, 501 W. State st., Trenton
Waldron, Edward L., 910 Stuyvesant av., Trenton
Warter, Peter J., 717 W. State st., Trenton
Waters, Charles H., 928 W. State st., Trenton
Watov, Samuel E., 615 Beatty st., Trenton
Watson, Frederick S., 238 W. State st., Trenton
Watts, Wilbur, 436 E. State st., Trenton
Wayman, Bernard R., 1100 S. Broad st., Trenton
Wiesler, Howard M., Drawer N, Trenton
Wikoff, John L., 799 Pennington av., Trenton
Williams, Harry D., 829 W. State st., Trenton
Wilner, Arthur S., 225 W. State st., Trenton
Wilner, Irving, 225 W. State st., Trenton
Wilson, Joseph G., N. J. State Hospital, Trenton
Wolff, Herbert M., 942 W. State st., Trenton
Yaeger, Leslie A., 470 Hamilton av., Trenton
York, Wilbur H., Box 110, Princeton
Zimskind, Joshua N., 210 W. State st., Trenton

ASSOCIATE MEMBERS

Berkowitz, Eva R., 110 Buckingham av., Trenton
Buford, Charles C., Jr., 507 S. Warren st., Trenton
Burell, Vincent A., 9 Carlton av., Trenton
Burroughs, Charles W., 733 W. State st., Trenton
Christian, Elizabeth I., Station A, Trenton
Cone, Thomas E., Jr., 108 N. Stanworth dr., Princet'n
Crane, Warren E., 11 Aberfeldy dr., Trenton
Freund, Seelig, 617 W. State st., Trenton
Frosch, Frank J., 1423 Pennington rd., Trenton
Gardiner, Muriel M., Brookdale Farm, Pennington
Gian-Grasso, Joseph A., 971 S. Broad st., Trenton
Hall, Mary B., 4 West Chestnut st., Bordentown
Hardin, Edmund B., 30 Lillian st., Trenton
Haslam, Herbert M., Peddie School, Hightstown
Kandle, Roscoe P., 20 Edgemere av., Trenton
Katzenbach, C. Buckman, 415 W. State st., Trenton
Lynch, Cornelius G., River rd., Yardley, Pa.
Mather, William B., 37 Edwards pl., Princeton
McCormack, Raymond A., 873 Bellevue av., Trenton
Migliori, Angelo, 531 S. Clinton av., Trenton
Moore, William J., 10 N. Olden av., Trenton
Philo, Seymour S., 849 Hamilton av., Trenton
Robinson, Irving W., 835 East State st., Trenton
Schnur, Bernard, 731 W. State st., Trenton
Schwager, Alfred J., Mercer Hospital, Trenton
Seely, Richard H., 3801A Ches'p'ke blvd.,S.H'mpt'n,V.
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Williams, Paul T., 626 Perry st., Trenton
Witman, H. John, Jr., 526 N. Clinton av., Trenton
Zeltmacher, Kurt, 306 W. State st., Trenton

HONORARY MEMBERS

Fell, Alton S., Trenton
MacFarland, Burr W., Trenton
Pierson, Theodore A., Hopewell
Taylor, Walter A., Trenton
Turner, Irvine F. P., Titusville

MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets on the third Wednesday of each month, October to June, inclusive. Annual Meeting in December.

ACTIVE MEMBERS

Adler, Howard E., 103 Livingston av., New Bruns'k
Adler, Lydia, 103 Livingston av., New Brunswick
Anderson, John F., 195 College av., New Brunswick
Avery, Philip S., Woodland ter., Bound Brook
Balogh, William A., 315 Dunellen av., Dunellen
Barbano, Alfred J., 225 Hale st., New Brunswick
Barnhardt, Russell A., 10 Deerfield rd., Parlin
Bassett, Lavern C., 320 New Market rd., Dunellen
Becker, Sidney D., 140 Maple pl., Keyport
Belafsky, Henry A., 150 Green st., Woodbridge
Berkow, Samuel G., 280 Hobart st., Perth Amboy
Bowman, Ned O., 1001 Georges rd., New Brunswick
Breslow, Samuel, 157 Market st., Perth Amboy
Brezinski, Edward J., 308 Washington st., P. Amboy
Brody, Morton S., 67 Paterson st., New Brunswick
Brown, Chester T., 102 N. Sixth av., Highland Park
Burnett, Charles B., 109 Main st., South River
Calvin, Charles H., 80 Commerce st., Perth Amboy
Cannata, Benjamin, 113 Market st., Perth Amboy
Church, Charles F., 192 College av., New Brunswick
Clarke, Francis M., 116 New st., New Brunswick
Cole, Nathaniel B., 104 Market st., Perth Amboy
Cooper, Irving J., 419 George st., New Brunswick
Cooperman, Eli L., 527 New Brunswick av., Fords
Copleman, Benjamin, 280 Hobart st., Perth Amboy
Copleman, Hyman B., 111 Liv'gst n av.,NewBruns'k
Cottrell, Judson G., 159 Market st., Perth Amboy
Degenhardt, Ira H., 114 S. First st., Highland Park
Dieker, Howard E., 78 Main st., South River
Downing, Perley E., N. J. State Hospital, Trenton
Downs, Louis S., 164 Pershing av., Carteret
Dunham, Malcolm M., 88 Grove av., Woodbridge
Duschock, Edward F., 473 Amboy av., Perth Amboy
Eulner, Elmer H., 216 Henry st., South Amboy
Fanelli, Antonio, 494 Compton av., Perth Amboy
Faulkingham, Ralph J., 61 Liv'gst'n av.,NewBr'ns'k
Feher, Ladislas A. M., 177 Somerset st., NewBr'ns'k
Fine, Hyman P., 151 Market st., Perth Amboy
Fine, Irvin J., Hobart Bldg., Perth Amboy
Finnegan, William R., 153 Somerset st., N. Brunsw'k
Fishkoff, Alexander H., 132 Market st.,Perth Amboy
Fithian, George W., 266 High st., Perth Amboy
Forney, Norman N., 94 N. Main st., Milltown
Forney, Norman N., Jr., Stelle av., Milltown
Freeman, William S., 117 N. Third av., Highland Pk.
Friedenthal, Bernard, 88 Livingston av.,NewBr'ns'k
Gadek, Stanley A., 95 Fayette st., Perth Amboy
Gadek, William V., 215 High st., Perth Amboy
Gerard, Arpad G., 502 Rahway av., Woodbridge
Gessner, Gerard R., 46 Union st., New Brunswick
Glasser, Benjamin F., 32 Lindon av., Highland Park
Gobel, Stanley J., Box 284, Bound Brook
Goldberg, Harry C., 7 Watchung av., Plainfield
Goldberg, Isidore, 303 N. Washington av., Dunellen
Goldman, Solomon, 161 Livingston av., New Br'ns'k
Gorog, Nicholas M., 159 Bayard st., New Brunswick
Greenwood, William R., Rensselaer, Indiana
Grossman, Walter, 77 Livingston av., N. Brunswick
Gurshman, Sol., 280 Amboy av., Metuchen
Gutowski, Joseph M., 433 Brace av., Perth Amboy
Hamburg, Meyer M., 60 N. Sixth av., Highland Pk.
Hauber, Eugene A., 198 Washington rd., Sayreville
Haywood, Henry, 49 Paterson st., New Brunswick
Henry, Frank C., Jr., 214 Smith st., Perth Amboy
Hesseltine, Clair E., 305 Main st., South Amboy
Hilker, George F., 258 Maple st., Perth Amboy
Hofer, Clarence J. M., 463 Main st., Metuchen
Hoffman, Charles W., 226 David st., South Amboy
Hoffman, Florentine M., 91 Bayard st., New Bruns k
Howell, E. Gaylord, 120 New st., New Brunswick
Howley, Barth, Jr., 67 Livingston av., New Brunsw'k
Hunt, Melvin M., 140 Jackson st., South River
Hutner, Cyril I., 134 Grove av., Woodbridge
Jacobson, Benjamin D., 187 Liv'gst'n av.,N.Br'nsw'k
Jacobson, Murray B., 137 Market st., Perth Amboy
Karshmer, Nathan, 92 Carroll pl., New Brunswick
Kemeny, Imre, 48 Pulaski av., Carteret
Kleiber, Estelle E., 131 Livingston av.,NewBrunsw'k
Klein, Edward F., 136 Market st., Perth Amboy
Klein, William, 85 Bayard st., New Brunswick
Kler, Joseph H., 151 Livingston av., New Brunswick
Koelsch, Frederick J., 14 Kirkpatrick st.,NewBr'ns'k

Koenig, Robert E., Sedgwick st., Jamesburg
Kohut, George J., 436 Amboy av., Perth Amboy
Krafchik, Louis L., 158 Livingston av., N. Brunswick
Kramer, Bernard M., 254 State st., Perth Amboy
Kramer, Samuel E., 254 State st., Perth Amboy
Lang, Joseph, 111 Market st., Perth Amboy
Lang, Joseph T., 115 Main st., South River
Lavine, Samuel C., 502 Georges rd., New Brunswick
Lazow, S. Manlius, 199 Main st., Matawan
Leonard, George F., 63 N. 5th av., Highland Park
Levinson, Reuben, 123 Market st., Perth Amboy
Lewis, Collins E., 219 Seaman st., New Brunswick
Lief, Lawrence H., Gatzmer av., Jamesburg
Lind, Zoltan H., 215 Livingston av., New Brunswick
London, Isabel M., 103 N. Fourth av., Highland Pk.
London, William, 255 State st., Perth Amboy
Long, Pauline A., 22 Livingston av., New Brunswick
Lucey, James J., 184 Market st., Perth Amboy
Mangogna, Philip, 334 Barclay st., Perth Amboy
Mann, Benjamin, 527 Amboy av., Perth Amboy
Mann, Jacob J., 255 State st., Perth Amboy
Margaretten, Edward I., 280 Hobart st., PerthAmb'y
Marino, Benjamin, 14 Llewellyn pl., N. Brunswick
Mark, Joseph S., 102 Green st., Woodbridge
Marvin, Dorothy H., 51 Livingston av., New Br'sw'k
McCormick, Wm. H., Jr., 266 Market st., P'thAmboy
McGovern, John F., Jr., 24 Liv'gst'n av.,NewBr'ns'k
McKiernan, Robert L., 97 Bayard st., New Brunsw'k
McKinstry, John W., Railroad av., Jamesburg
McLeod, Neill S., 729 Raritan av., Highland Park
Meinzer, Martin S., 147 Market st., Perth Amboy
Miller, S. David, 90 Carroll pl., New Brunswick
Moolten, Sylvan E., 103 N. Fourth av., Highland Pk.
Morris, Carlyle, Spring street, Metuchen
Nafey, Herbert W., 51 Livingston av., NewBrunsw'k
Naulty, Chas. W., Jr., 403 High st., Perth Amboy
Nieman, Solomon Z., 191 Livingston av., NewBr'ns'k
Normand, Alphonse F., 267 High st., Perth Amboy
O'Connell, James J., 116 Livingston av., NewBr'ns'k
Panigrosso, Louis R., 455 Lawrie st., Perth Amboy
Pansy, Abraham A., 12 Jackson st., South River
Pellicane, Anthony J., 183 Liv'gst'n av., New Br'ns'k
Putter, Eric, 180 N. Main st., Milltown
Racz, George, 22 Hardenberg st., New Brunswick
Reason, John J., 612 Roosevelt av., Carteret
Reitman, Norman, 155 Livingston av., New Brunsw'k
Rineberg, Irving E., 137 Livingston av.. NewBr'ns'k
Romano, Frank, 207 Front st., Dunellen
Rona, Maurice, 10 Kirkpatrick st., New Brunswick
Rosenberg, Norman, 10 Lincoln av., Highland Park
Rothfuss, C. Howard, 574 Rahway av., Woodbridge
Rothschild, Karl, 149 Livingston av., New Brunsw'k
Rowland, John H., 159 New st., New Brunswick
Rubin, William, 105 Carroll pl., New Brunswick
Runyon, Laurence P., 80 Somerset st., New Bruns'k
Salaky, William L., 387 Neville st., Perth Amboy
Sandella, Jos. F., 138 Livingston av., New Brunsw'k
Saulsberry, Chas. E., 75 Livingston av., New Br'ns'k
Schirber, Rene G., 6 Kirkpatrick st., New Brunsw'k
Scott, Frederick W., 103 Bayard st., New Brunswick
Sender, Fannie, 193 Main st., South River
Shangold, Jack E., 280 Hobart st., Perth Amboy
Shayevitz, Abraham S., 102 Main st., South River
Sherman, W. Edgar, 7 Livingston av.,NewBrunsw'k
Shull, John V., 184 Kearny av., Perth Amboy
Siegel, Isadore, 121 Market st., Perth Amboy
Siegel, Ralph E., 111 Market st., Perth Amboy
Silber, Irving M., 75 Livingston av., New Brunswick
Silk, Charles I., 236 High st., Perth Amboy
Slobodien, Benjamin F., 233 High st., Perth Amboy
Smith, Ivan B., Georges rd., Dayton
Smith, John A., 106 Main st., South River
Smith, John V., 463 State st., Perth Amboy
Smith, Joseph A., N. J. Sanatorium, Glen Gardner
Smith, Marshall, 62 Bayard st., New Brunswick
Smith Sydney F., 402 Raritan av., Highland Park
Sokoloff, Oscar J., 69 Paterson st., New Brunswick
Spencer, Ira T., 152 Main st., Woodbridge
Spritzer, Theodore D., 102 S. Wash'gt'n av.,Dunellen
Stein, William, 177 Livingston av., New Brunswick
Sullivan, Chas. J., 57 Paterson st., New Brunswick
Szuch, Nicholas, 159 Main st., South River
Taber, Frederick S., 55 Paterson st., N. Brunswick
Tisch, Leon, 28 S. Third av., Highland Park
Toy, Calvert R., 22 Kirkpatrick st., New Brunswick
Tucker, Sidney, 211 Madison av., Perth Amboy
Tyrrell, George W., 380 State st., Perth Amboy
Uhr, Jacques S., 127 Livingston av., New Brunsw'k
Ulan, Jerome, Main st., Spotswood
Urbanski, Matthew F., 148 Market st., Perth Amboy
Van Mater, John S., 61 Livingston av., N. Brunswick
Vargyas, Joseph C., 116 New st., New Brunswick
Walker, Robert B., 108 Church st., New Brunswick
Walters, George M., 158 Main st., Woodbridge
Wantoch, Joseph, 14 Carteret av., Carteret
Weber, John F., 264 Main st., South Amboy
Weiner, Henry T., 280 Hobart st., Perth Amboy
Wetterberg, Louis F., 74 Grove av., Woodbridge
White, Harry J., Roosevelt Hospital, Metuchen
Wiesenfeld, Benjamin, 138 Market st., Perth Amboy
Wiesenfeld, Paul, 138 Market st., Perth Amboy
Wilentz, William C., 188 Market st., Perth Amboy
Witmer, John D., 456 Middlesex av., Metuchen

ASSOCIATE MEMBERS

Becker, Meyer, 219 Amboy av., Metuchen
Berkow, Bori, 245 State st., Perth Amboy
Bielski, Johannes F., 180 Somerset st., N. Brunswick
Boogdanian, Victor H., 316 George st., N. Brunswick
Bristol, Frank E., II, Main st., Dayton
Brown, Milton B., 72 Roosevelt av., Carteret
Budnicki, Xavier B., 105 Broad st., Perth Amboy
Cowen, Mortimer I., 1330 Oak Tree rd., Iselin
Frederick, George F., 179 Main st., Woodbridge
Gould, Louis F., 95 Market st., Perth Amboy
Ittleman, William S., 307 N. Wash'gton av.,Dunellen
Jasionowski, Edward, 121 Main st., Sayreville
Kant, Emanuel R., 240 High st., Perth Amboy
Kluft, Jack M., 280 Hobart st., Perth Amboy
Kunderman, Philip J., 215 Harper st., Highland Park
Leonard, Martha F., 55 N. 5th av., Highland Park
Miller, Clark F., Mass. Gen. Hosp., Boston 18, Mass.
Morgenstern, Mates, 341 George st., New Brunswick
Myer, Clifton G., 390 Avenel av., Avenel
Niemiera, Alex K., 509 State st., Perth Amboy
Pickar, Gabriel, 205 N. 2nd av., Highland Park
Sadoff, Irvin E., 163 New st., New Brunswick
Scalera, John F., 28 S. Plainfield av., So. Plainfield
Stollman, Bernard D., 21 John st., New Brunswick
Urban, George J., Jr., 40 Egan st., Fords
Winn, James S., 131 Walnut st., Bound Brook
Winn, William M., 128 Broad st., Perth Amboy

HONORARY MEMBERS

Burnett, Charles B., South River
Henry, Frank C., Perth Amboy
Spencer, Ira T., Woodbridge
Tyrrell, George W., Perth Amboy
Voorhees, Howard C., New Brunswick

MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets on fourth Wednesday of each month from September to June, inclusive. Annual Meeting in April.

ACTIVE MEMBERS

Adler, Samuel, 229 Broad st., Red Bank
Albright, Louis F., 118 Madison av., Spring Lake
Altschul, Frank J., 177 Garfield av., Long Branch
Baer, Irving, 141 Broad st., Red Bank
Baeseman, R. Winfield, 112 Main st., Allenhurst
Baker, Elsworth F., N. J. State Hosp., Marlboro
Bar, Samuel, Englishtown
Barnett, Lester A., 1201 Grand av., Asbury Park
Binder, Joseph, 101 Third av., Long Branch
Blaisdell, C. Byron, 489 Broadway, Long Branch
Booth, Herbert W., 4th & Jersey avs., Spring Lake
Bornstein, Paul K., 601 Grand av., Asbury Park
Bossone, Joseph E., 362 Bath av., Long Branch
Boyd, John B., 31 Oakland st., Red Bank
Bregman, Milton, 81 Union av., Manasquan
Brindle, Harry R., 501 Grand av., Asbury Park
Brown, Edith L., 340 Garfield av., Avon
Brown, Kenneth G., 501 Grand av., Asbury Park
Burkhead, Howard C., 541 Broadway, Long Branch
Captanian, Aram A., 166 Main st., Matawan
Carey, David S., 11 E. Main st., Freehold
Carter, Joseph F. S., 142 Atkins av., Asbury Park
Ciampa, Ralph P. E., 119 Morris av., Long Branch
Clark, John C., 501 Grand av., Asbury Park
Colby, Maxwell X., 133 Chelsea av., Long Branch
Cooper, Jehu P., Box 74, Matawan
Daversa, Benjamin, 209 Passaic av., Spring Lake
Dedick, Andrew P., Jr., 118 Branch av., Red Bank
Delcau, Jules, 56 W. Main st., Freehold
D'Elia, William J., 1100 Third av., Spring Lake
Demaree, Richard H., 310 Norwood av., W.L'gBr'nch
Dengrove, Edward, 314 Grassmere av., Interlaken
dePons, Sarah C., 501 Grand av., Asbury Park
DeSimone, Louis E., 508 Fifth av., Asbury Park
DeVita, Anthony J., Wilson av., Port Monmouth
Diamond, David I., Oceanport av., Oceanport
Dimitrow, Helen, 236 Broad st., Red Bank
Dorr, Henry B., 466 Broadway, Long Branch
Duisberg, Richard E. H., N. J. State Hosp., Marlboro
Duvall, Albert I., N. J. State Hospital, Marlboro
Edelson, Samuel, 1611 Grand av., Asbury Park
Fazio, Vincent J., 104 Maple av., Red Bank
Featherston, Daniel F., 601 Bangs av., Asbury Park
Feinberg, Harry D., 384 Second av., Long Branch
Feman, J. George, 141 Main st., Keansburg
Fenton, Tennant E., 320 Ludlow av., Spring Lake
Fisher, James A., 501 Grand av., Asbury Park
Freedman, Harold H., 63 W. Main st., Freehold
George, Amerigo, 153 Third av., Long Branch
Gesswein, Carl A., 35 Church st., Matawan
Goff, Frank J., 62 Maple av., Red Bank
Goldstein, Benjamin, 710 Madison av., Asbury Park
Gordon, J. Berkeley, N. J. State Hosp., Marlboro
Graber, Irving, 500 Tenth av., Belmar
Haines, Emerson S., 614 Windermere av., Asbury P.
Halbstein, Bernard M., 138 Bath av., Long Branch
Hancock, Michael Q., Third av. & River rd., Belmar
Hardy, John W., 53 Main st., Farmingdale
Hart, Francis F., 501 Grand av., Asbury Park
Hausman, Samuel W., 50 W. Front st., Red Bank
Haut, Edward M., 21 Main st., Farmingdale
Heatley, William, 29 Drummond pl., Red Bank
Herrman, William G., 501 Grand av., Asbury Park
Heymann, Ernest F., 345 Broad st., Red Bank
Hindle, F. Lawton, 145 Maple av., Red Bank
Hodas, Sidney M., 268 Broad st., Red Bank
Holman, Francis W., 123 Broad st., Keyport
Holters, Otto R., 1002 Emory st., Asbury Park
Hummel, Frederick W., 606 F st., Belmar
Isen, Paul J., 600 Third av., Bradley Beach
Jamison, William F., 501 Grand av., Asbury Park
Jarecki, Max M., 905 Bergh st., Asbury Park
Jones, Helen E., 617 Seventh av., Asbury Park
Jordan, Joseph C., Box A, Manasquan
Kahrs-Dreyfors, Madeline, N.J. State Hosp.,Marlb'ro
Kazmann, Harold A., 601 Grand av., Asbury Park
Knapp, Victor, 505 Second av., Asbury Park
Koch, William, 1000 Grand av., Asbury Park
Krohn, Marc, Campbell av., Belford
Lehmann, Otto, 138 Bath av., Long Branch
Leonard, Lothair L., 615 Asbury av., Asbury Park
Levin, Jack, 95 W. Main st., Freehold
Lewis, Jacob, 43 Court st., Freehold
Long, Elias E., 85 W. Front st., Red Bank
Lovett, Irving K., 110 E. Front st., Red Bank
Luca, Frank, 563 Westwood av., Long Branch
Luca, Mildred O., 563 Westwood av., Long Branch
Lussier, Georges H.,Brisbane Tr'tm't Cen.,Farm'gd'le
MacKenzie, Robert A., 501 Grand av., Asbury Park
Maher, John E., 90 Third av., Long Branch
Makin, John B., 501 Grand av., Asbury Park
Martin, Leonard J., Box 431, Asbury Park
Matthews, William, 139 Broad st., Red Bank
McCreight, David W., N. J. State Hosp., Marlboro
McCurdy, Robert G., 74 W. Highland av.,Atl.Highl'ds
McDonnell, George J., 80 W. Main st., Freehold
McGreevey, Harold, 314 Brighton av., Spring Lake
McKelvie, Julius C., 55 Rockwell av., Long Branch
McTague, Robert S., 37 E. Wash'gt'n av.,Atl.Highlds
Miele, Frank A., 314 Carr av., Keansburg
Mohair, John P., N. J. State Hosp., Marlboro
Mulligan, Edward W., 81 Shrewsbury av., Red Bank
Nathanson, Norman, 489 Broadway, Long Branch
Nichols, Stanley H., 517 Broadway, Long Branch
Osborn, A. Downey, 415 Fourth av., Belmar
Parry, Oliver K., 601 Bangs av., Asbury Park
Payne, Douglas, 501 Grand av., Asbury Park
Perrine, Cornelius C., 668 River rd., Fair Haven
Perrotta, Anthony J., 42 Harding rd., Red Bank
Pieper, Howard C., 120 Main st., Keyport
Pietri, Raoul, 501 Grand av., Asbury Park
Pignataro, Frank P., 342 Broad st., Red Bank
Pleasants, Edward N., N. J. State Hosp., Marlboro
Podell, A. Alfred, 51 E. Front st., Red Bank
Pons, Carlos A., 501 Grand av., Asbury Park
Pregnall, James P., 501 Grand av., Asbury Park
Quirk, Martin A., 69 W. Front st., Red Bank
Raffetto, Joseph F., 601 Bangs av., Asbury Park
Raphael, Chester M., N. J. State Hospital, Marlboro
Reynolds, Donald G., 64 W. Main st., Freehold
Reynolds, George G., 64 W. Main st., Freehold
Rifici, Anthony L., 1010 Grand av., Asbury Park
Robinson, Ernest A., 149 Atkins av., Asbury Park
Robinson, William A., 62 Main av., Ocean Grove
Rocco, Leo C., 75 Maple av., Red Bank
Rosenthal, Abraham, 43 Third av., Atl. Highlands
Rubin, Adrian D., 401 First av., Asbury Park
Rubin, Jacob S., 505 Fourth av., Asbury Park
Rullman, Walter A., 58 W. Front st., Red Bank
Sacco, Gregory E., 191 Broad st., Red Bank
Schlossbach, Theodore, 94 S. Main st., Ocean Grove
Schmaler, Sica L., 607 Fifth av., Belmar
Schmidt, Albert F., 521 Crescent Parkway, Sea Glrt
Schnelder, Leonard, 618 Brinley av., Bradley Beach

Sewell, Stephen, 320 Passaic av., Spring Lake
Shanik, William, 710 Mattison av., Asbury Park
Shapiro, Saul J., 50 E. Lincoln av., Atl. Highlands
Siegel, Victor, 43 E. Front st., Red Bank
Slocum, Harry B., 263 Bath av., Long Branch
Stellar, Frederick C., 220 St. Clair av., Spring Lake
Stevenson, George S., R. D. Box 556, Red Bank
Strauss, Arthur, 130 Pavilion av., Long Branch
Thompson, Victor, 80 W. Front st., Keyport
Trippe, Morton F., 702 Asbury av., Asbury Park
Upham, Helen F., 305 Third av., Asbury Park
Verga, Armand, 20 Main st., Manasquan
Villapiano, Joseph G., 701 Sunset av., Asbury Park
Von Oehsen, William H., 623 4th av., Bradley Beach
Wainright, Melvin A. R., 286 Broad st., Red Bank
Whelan, Vincent, 67 E. Front st., Red Bank
Wilbur, Franklin L., 515 Eighth av., Asbury Park
Wilkins, Stanley O., 47 E. Front st., Red Bank
Willey, Harry S., Jr., 112 Broad st., Red Bank
Wilson, Robert B., 48 Riverside av., Red Bank
Woodruff, Ralph G., Main st., Englishtown

ASSOCIATE MEMBERS

Banta, Edward E., 64 Peters pl., Red Bank
Bruzza, George, 415 Washington Boulevard, Sea Girt
Collis, Abraham S., 156 Atlantic av., Long Branch
Guito, Frank, 626 Mattison av., Asbury Park
Knowles, Frederick, 300 Brooklyn Blvd., Sea Girt
Korbonits, Charles W., 1117 Sunset av., Asbury Park
Movelle, John, 840 River rd., Fair Haven
Pisani, Anthony A., Branch av., Little Silver
Spagnolo, Peter J., 1101 Grand av., Asbury Park
Thetford, Norman D., 68 South st., Eatontown
Tilley, John A., 165 Main st., Keyport
Weinstein, Alvin, 710 Mattison av., Asbury Park
Winder, Miles S., Jr., 701 Third av., Asbury Park

HONORARY MEMBERS

Bryan, Joseph H., Asbury Park
Donovan, William F., Brielle
Hill, John A., Allenhurst
Jones, Granville L., Williamsburg, Virginia
Ransohoff, Nicholas S., Long Branch
Stewart, Edwin F., Fair Haven
Straughn, Clinton C., Red Bank

MORRIS COUNTY (14)

Society organized June 11, 1816. Meets on the third Thursday in October, December, March and June. Annual Meeting in June.

ACTIVE MEMBERS

Abraham, Albert, 15 Altamont ct., Morristown
Alcaro, Joseph A., 85 Summit av., Wharton
Atkinson, John M., 93 Greenwood av., Madison
Baker, Augustus L., 389 W. Blackwell st., Dover
Baker, Augustus L., Jr., 389 W. Blackwell st., Dover
Beard, James R., Jr., Taff dr., Millington
Beaver, Jennie D., 44 Elm st., Morristown
Benz, Francis J., 30 Lum av., Chatham
Bertha, Nicholas A., 83 S. Main st., Wharton
Bird, Frank L., Main st., Netcong
Blake, Dexter B., R. F. D. 1, Far Hills
Blanchard, Charles L., 28 E. Blackwell st., Dover
Bobadilla, Juan E. B., 293 S. Main st., Wharton
Booth, William K., 304 William st., Boonton
Borkow, Philip, 45 E. Blackwell st., Dover
Bowers, F. Clyde, Mountain av., Mendham
Breuder, Andrew B., Whippany rd., Whippany
Byrne, J. Arthur, 16 Elm st., Morristown
Carleton, Charles K., 266 S. Main st., Wharton
Cohen, Oscar H., 115 Church st., Boonton
Collins, Laurence M., N.J. State Hosp.,Greyst'ne P'k
Comeau, George W., 415 Speedwell av.,Morris Plains
Cook, Dora G., 317 Cornella st., Boonton
Corwin, Emanuel M., 5 Richards av., Dover
Costello, William F., 55 W. Blackwell st., Dover
Coultas, Aldo B., 1 Madison av., Madison
Cummins, Ella F., 39 Elm st., Morristown
Curry, Marcus A., N. J. State Hosp., Greystone Park
Dailey, Jeremiah, 57 Madison av., Madison
DeFelice, Mario T., 790 E. Clarke pl., Orange
Deichman, Charles H., 39 Elm st., Morristown
Dirdack, Morris, 13 DeHart st., Morristown
Dochtermann, Warren P., R. D. 1, Stanhope
Donovan, Joseph, N. J. State Hosp., Greystone Park
Dredge, Thomas J., N. J. State Hosp., GreystonePk.
Earp, Ruth, 15 Olcott av., Bernardsville
Eckhardt, Ralph A., 50 Green Village rd., Madison
Emory, George B., Jr., 1 Franklin pl., Morristown
Esposito, Amedeo C., N. J. State Hosp.,GreystonePk.
Evans, Edgar J., Second av., Denville
Fallmezger, Theodore R., 125 Green av., Madison
Falvello, Nicholas A., 21 Wetmore av., Morristown
Ferriss, Ruth B., 8 Wetmore av., Morristown
Finby, Nathaniel, 46 Main st., Netcong
Foley, James G., Bernardsville
Forbes, John S., Jr., W. Craig st., Basking Ridge
Gambill, Perry J., N. J. State Hosp., Greystone Park
Gantt, Margaret H., 43 Hillcrest rd., Madison
Geary, Daniel J., 5 Community pl., Morristown
Gebirtig, Theodore, 181 South st., Morristown
Gianni, Angelo R., 37 Main st., Netcong
Gilbertson, Robert L., 26 Maple av., Morristown
Giordano, Salvatore, 13 DeHart st., Morristown
Glazebrook, Francis H., "HoneysuckleW'ds,"Rumson
Gordon, Charles D., Mt. Arlington
Graddick, Lester W., 22 Sussex av., Morristown
Grant, Raymond J., 117 S. Main st., Wharton
Gregory, Marie F., 50 Green Village rd., Madison
Griscom, I. Norwood, 204 Church st., Boonton
Hampton, George R., N.J. State Hosp.,GreystonePk.
Harrington, J. Henry, 126 E. Main st., Rockaway
Hatch, Harold S., Shonghum Mt. Sana., Morristown
Haven, Samuel C., 14 Elm st., Morristown
Hiler, Stuart A., 62 Rockaway av., Rockaway
Hogan, Marshall D., 311 W. Main st., Boonton
Hopper, John B., E. Main st., Mendham
Hopping, John S., River rd., Hanover
Hornick, Emil E., 6 Altamont ct., Morristown

Hubert, Antonio O., 131 E. Main st., Rockaway
Ivey, Evelyn P., 3 Community pl., Morristown
Johnston, Julian F., 21 Van Doren av., Chatham
Kent, Donald F., 396 Main st., Chatham
Kessler, Edward I., N.J. State Hosp., Greystone Pk.
King, Alden P., 400 W. Blackwell st., Dover
Klein, Milton, 45 E. Blackwell st., Dover
Klein, Solomon, 11 High st., Morristown
Kossmann, Walter J., Long Valley
Krauss, Fletcher I., 407 Main st., Chatham
Kuite, George B., 435 Speedwell av., Morris Plains
Larson, Henry M., 35 Franklin st., Morristown
Lathrope, George H., 965 Broad st., Newark
Laudig, Guy H., 361 Speedwell av., Morris Plains
Levendusky, Daniel E., 20 W. Main st., Rockaway
Lewin, Leo, Howard Blvd., Mt. Arlington
Luddecke, Hugh F., 40 Franklin st., Morristown
Luippold, Eugene J., Jr., 130 Fairview av., Boonton
Mathews, Raymond H., 186 South st., Morristown
McMahon, Bernard C., 15 James st., Morristown
McMurtrie, William A., 20 Franklin st., Morristown
Melvin, Daniel G., N. J. State Hosp., Greystone Park
Menden, Julian, 45 E. Blackwell st., Dover
Mills, Clifford, 36 Maple av., Morristown
Mintz, Alvin R., 32 Maple av., Morristown
Musetto, Carmelo A., 135 Cornelia st., Boonton
Navazio, Attilio, 29 DeHart st., Morristown
Nicoll, George L., 25 McDavitt pl., Dover
Oestreicher, Harry, Picatinny Arsenal, Dover
Palazzo, William L., 2210 Starling av., Bronx, N. Y.
Parry, Allen A., 54 Green av., Madison
Parry, Antoinette R., 54 Green av., Madison
Patton, Paul B., 3 Winding Way rd., Morris Plains
Pinckney, Frank H., 186 South st., Morristown
Plume, Clarence A., Main st., Succasunna
Pottinger, William E., 6 Altamont court, Morristown
Prager, Bert A., 511 Main st., Chatham
Reed, Robert R., 65 Washington st., Morristown
Renna, Francis, 20 Morris av., Morristown
Rice, Franklin W., 184 South st., Morristown
Rosen, Herbert J., 42 Hudson st., Dover
Rosenberg, Alvin A., 22 High st., Morristown
Rubens, Otto, 153 E. Blackwell st., Dover
Ryman, Merlin T., 5 Dunbar st., Chatham
Sagert, Carl M., 18 Old Wood rd., Morris Plains
Saltus, Lloyd S., 16 Elm st., Morristown
Schumacher, Evelyn L., 32 Maple av., Morristown
Seward, Frederic H., 40 Green Village rd., Madison
Shanik, Morton J., 55 W. Blackwell st., Dover
Spencer, Alvan, 395 W. Blackwell st., Dover
Stage, Earl DeW., 1 Crestwood rd., Morristown
Steuart, David F. R., 9 Armstrong rd., Morristown
Talmage, William G., Main st., Succasunna
Teller, Daniel W., Jr., 28 DeHart st., Morristown
Terreri, D. Joseph, 30 High st., Morristown
Teskey, Stanley, 10 Anderson rd., Bernardsville
Thomas, Thomas S., Jr., 18 Elm st., Morristown
Truax, Alfred J., Chester
Van Wiemokly, Seymour S.,201 Speedw'l av.,Morrist'n
von Deilen, Henry O., 28 DeHart st., Morristown
Voorhies, Wm. S., Jr., N.J. State Hosp.,GreystonePk.
Voss, J. Landon, 212 South st., Morristown
Ward, Albert J., 39 Elm st., Morristown
Warne, Merna M., N.J. State Hosp., Greystone Park
Weiss, Herman, Aurora Institute, Morristown
Williams, David P., 116 Lake dr., Mountain Lakes
Williams, Louis E., 80 Green av., Madison
Woodman, Charles B., 212 South st., Morristown
Young, George J., 60 Maple av., Morristown
Zimmerman, Robert F., 28 Wash'gton av.,Morrist'n
Zuloff, D. Blair, 3 Community pl., Morristown

OCEAN COUNTY (15)

Society organized October 28, 1903. Meets on second Wednesday of each month except July and August. Annual Meeting in May.

ACTIVE MEMBERS

Alpert, Sidney, 235 Fourth st., Lakewood
Appleton, Ralph, Lincoln av., Point Pleasant
Blumberg, A. William, New Egypt
Buermann, Robert, 206 Madison av., Lakewood
Bunnell, Frederick N., 22 S. Main st., Barnegat
Carmona, L. Roberto, 141 Wood st., Tuckerton
Dodd, William E., Ocean st. & Bay av., Beach Haven
Falkinburg, LeRoy W., Collingswood
Gartlan Bernard W., Main st., Toms River
Gebele, William X., Jr., 310 Main st., Lakewood
Goldstein, Abraham, 404 Madison av., Lakewood
Gove, Richard R., Jr., 46th & Boulevard, Brant B'ch
Green, Thomas J., New Egypt
Hayden, Walter G., 504 Main st., Toms River
Henriksen, J. Bruce, 422 River av., Point Pleasant
Herbener, Eugene G., 423 Third st., Lakewood
Ivory, Harry S., Richmond av., Point Pleasant
Jaffe, Gorman, 626 Sixth st., Lakewood
Lehmacher, Frank, 16 Central av., Lakewood
Menge, Carl H., 236 Washington st., Toms River
Mitchell, Willis B., W. Washington st., Toms River
Nyvall, Pierre J., Barnegat
Obert, J. Edwin, Main st., New Egypt
Pecora, Carmine L., 212 Washington st., Toms River
Rinzler, Harvey, 614 Main st., Toms River
Sawyer, Blackwell, 109 Washington st., Toms River
Schneider, Clinton R., 125 N. Green st., Tuckerton
Sickel, Emanuel M., 318 Forest av., Lakewood
Szold, Norman F., 701 Princeton av., Lakewood
Taylor, Raymond A., 58 Madison av., Lakewood
Towbin, Adolph, 326 Third st., Lakewood
Wentz, Irl Z., 224 Webster av., Seaside Heights
Witte, C. Norman, 422 River av., Point Pleasant
Yurevich, Antony, County Line rd., Lakewood

PASSAIC COUNTY (16)

Society organized January 14, 1844; Society chartered November 14, 1843. Meets on third Tuesday of each month except June, July and August. Annual Meeting in May.

ACTIVE MEMBERS

Achtentuch, Herman, 113 Sherman st., Passaic
Ackerhalt, Martin J., 408 Clifton av., Clifton
Adler, Fritz F., 777 Market st., Paterson
Allen, Arthur A., 365 Park av., Paterson
Allen, Edwin J., 269 Carroll st., Paterson
Allen, James M., 585 Main st., Passaic
Alonzo, Gerard J., 477 Stuyvesant av., Lyndhurst
Alpren, Bernard F., 17 Church st., Paterson
Andrews, Albert G. K., 238 Sherman st., Passaic
Angell, Emmett D., 1 Catherine st., Bloomingdale
Apter, Abraham H., 45 Church st., Paterson
Aronsohn, Charles M., 459 Park av., Paterson
Ash, Frank W., 180 Carroll st., Paterson
Atwood, Edward A., 360 Park av., Paterson
Averbach, Jacob, 435 Clifton av., Clifton
Balles, Edward S., 392 Park av., Paterson
Barolsky, Benjamin, 452 15th av., Paterson
Barone, Leo J., 392 Van Houten st., Paterson
Barr, Joseph, 975 Madison av., Paterson
Baxt, Sidney J., 544 21st av., Paterson
Becker, Frank F., 337 E. Ridgewood av., Ridgewood
Becker, George L., 646 E. 28th st., Paterson
Becker, Leo V., 69 Ward st., Paterson
Bender, Theodore, 666 Broadway, Paterson
Benjamin, Joseph F., 203 Godwin av., Ridgewood
Berk, M. David, 505 Wanaque av., Pompton Lakes
Berkhout, Peter G., 106 Haledon av., Prospect Park
Bernson, Samuel T., 33 Bartholf av., Pompton Lakes
Beshlian, Hagop K., 7 Lee pl., Paterson
Biczak, Arkad K., 311 Lexington av., Clifton
Blake, Albert J., 640 Broadway, Paterson
Bohl, Louis J., 320 Broadway, Paterson
Bongiorno, Henry D., 516 River st., Paterson
Bornstein, David, 566 Broadway, Paterson
Botbyl, Burt W., 927 Madison av., Paterson
Boylan, Lawrence B., 630 Main st., Paterson
Brancato, Peter, 93 E. 38th st., Paterson
Brancone, Alphonse M., 417 21st av., Paterson
Brogan, Francis B., 600 Broadway, Paterson
Bromberg, Charles B., 107 Lexington av., Passaic
Bronner, Alfred, 47 Burgess pl., Passaic
Brooks, Sidney S., 380 12th av., Paterson
Budd, J. Reuben, 379 Clifton av., Clifton
Bullen, Victor E., 148 Hamilton av., Paterson
Butterfield, Arey A., 655 Main av., Passaic
Caliigaro, Egildo A., 288 Parker av., Clifton
Capeli, Harry H., 302 Broadway, Paterson
Capio, Mario D., 293 Broadway, Paterson
Carlisle, John H., 129 Prospect st., Passaic
Carlough, David J., 426 Ellison st., Paterson
Carusi, Leonardo G., 337 Park av., Paterson
Catanzaro, Francesco, 151 Jefferson st., Passaic
Chapnick, Maurice M., 715 Broadway, Paterson
Charney, William, 546 Broadway, Paterson
Cherry, Homer H., Valley View Sana., Paterson
Chester, Saul W., 634 Broadway, Paterson
Chilton, Forrest S., Pompton Plains
Chrisman, Irving, 423 Broadway, Paterson
Chudzik, Edward W., 269 Outwater lane, Garfield
Churg, Jacob, Barnert Memorial Hosp., Paterson
Ciccone, Anthony C., 389 Grand st., Paterson
Cichon, Elmer J., 679 Van Houten av., Clifton
Clark, Orlo H., 149 Prospect st., Passaic
Close, Byron H., Hamburg Turnpike, Bloomingdale
Cogan, Henry, 123 Depew av., Buffalo 14, N. Y.
Cohen, Julian, 592 E. 29th st., Paterson
Cohen, Louis, 257 Paulison av., Passaic
Cohen, M. Marvin, 582 E. 25th st., Paterson
Cohn, Isidor, 231 Lexington av., Passaic
Cole, L. Frank, 388 Terhune av., Passaic
Connolly, Joseph P., 56 Hamilton st., Paterson
Conserva, Peter V., 196 Randolph av., Clifton
Cortese, Alvin E., 26 Ward st., Paterson
Cotton, Norman T., 219 Graham av., Paterson
Cremens, John F., 144 Carroll st., Paterson
Crescente, Fred J., 836 Madison av., Paterson
Crounse, David R., 84 Broadway, Passaic
Curtis, A. Maurice, 445 Van Houten st., Paterson
Davis, A. Hobson, Paterson General Hosp., Paterson
Dawson, Harry, 618 E. 24th st., Paterson
DeBell, Peter J., 65 Summer st., Passaic
DeGrace, Francis H., 311 Paulison av., Passaic
Deich, Samuel R., 162 Lexington av., Passaic
Delario, Anthony J., 316 Broadway, Paterson
Della Penna, Samuel J., 320 Ramapo av., Pompton L.
Del Mauro, Alphonse, 460 Park av., Paterson
DeMattia, Michael, 71 Ward st., Paterson
Denison, Ward C., 316 Broadway, Paterson
DeRosa, Armand, 262 Totowa rd., Totowa
Desmet, Victor F., 324 Broadway, Paterson
De Yoe, Leon E., 602 Broadway Paterson
Dingman, Norman M., 330 Broadway, Paterson
Doktor, David, 415 Park av., Paterson
Donnelly, Joseph E., 445 Market st., Paterson
Drake, Daniel E., Union Valley rd., Newfoundland
Dren, George W., 191 Lexington av., Passaic
Duncan, Owsley B., 414 Ellison st., Paterson
Dwyer, Henry E., 261 Madison st., Passaic
Dwyer, William A., 99 Park av., Paterson
Edlkraut, Edward C., 320 Lexington av., Clifton
Edson, James, 336 Belmont av., Haledon
Ehrenfeld, Edward, 185 Lexington av., Passaic
Ehrenfeld, Irving, 185 Lexington av., Passaic
Eisemann, Jerome S., 38 Main st.. Butler
Ekings, Frank P., 221 Broadway, Paterson
Esposito, Anthony L., 246 Lexington av., Passaic
Farkas, Gustav, 255 Harrison st., Passaic
Feliciano, Vincent, 286 Lafayette av., Hawthorne
Fenster, Morton N., 202 Lexington av., Passaic
Fenwick, John R., 196 Lakeview av., Cilfton
Ferrari, Salvatore, 372 21st av., Paterson
Ferrary, Paul B., 232 Totowa rd., Totowa
Ficker, Robert F., Erskine Lakes, Wanaque
Fielding, William M., 15 Waidwick av., Waidwick
Fiering, Abraham M., Pompt'n Tnpk., Mount'n View
Fishbein, Elliot, Valley View Sana., Paterson
Fisher, Samuel, 808 Madison av., Paterson
Flitcroft, William, 214 E. College av., Waukesha, Wis.
Foote, Sherman K., Clinton av., Wyckoff
Fortay, Steven O., 474 Park av., Paterson
Fraulo, Louis, 347 Crooks av., Clifton
Freedman, Jacob S., 178 Hamilton av., Passaic
Friedman, Edna C., 584 Broadway, Paterson
Friedmann, Gustav, 425 Park av., Paterson
Gallardo, Agustin, 61 Lakeside av., Pompton Lakes
Gallo, James S., 39 Ellwood st., East Paterson
Garnett, Robert, 204 Madison st., Passaic
Ged, Archie K., 1133 Main st., Paterson
Geiger, Harold C., Main st., West Milford
Gellman, William B., 163 Valley Blvd., Wood-Ridge
Gelman, Sidney, 600 E. 27th st., Paterson
Giambra, Sante M., 400 Park av., Paterson
Giglio, Louis A., 411 S. Center st., Pottsville, Pa.
Ginsburg, Samuel, 227 Paulison av., Passaic

Gochman, Harry M., 166 Hamilton av., Paterson
Goldenberg, Raphael R., 588 E. 27th st., Paterson
Golding, Harry N., 180 Carroll st., Paterson
Goldstein, Edward W., 561 E. 28th st., Paterson
Golish, Harry L., 425 15th av., Paterson
Gordon, Abel, 616 Main av., Passaic
Gordon, Samuel, 540 Park av., Paterson
Gordon, William, 648 Ringwood av., Wanaque
Gormley, Cyrus M., 320 Broadway, Paterson
Gould, John H., 92 Monte Vista av., Ridgewood
Graeter, F. Albert, 43 Barry pl., Passaic
Graham, Archibald F., 42 Park av., Paterson
Graham, Theodore K., 279 Park av., Paterson
Greengrass, Jacob J., 146 Broadway, Paterson
Greenwell, Albert W., 6 S. Brookwood dr., Montclair
Grossbard, Paul, 211 Lexington av., Passaic
Guarraia, Joseph, 285 Van Winkle av., Hawthorne
Gurnee, Quinby D., 168 Diamond Br. av., Hawthorne
Hall, Wayne W., 515 Broadway, Paterson
Hambright, Arthur M., Wyckoff av., Ramsey
Harreys, Charles W., 153 Prospect st., Ridgewood
Hatem, Elias J., 1046 Main st., Paterson
Hathaway, George, Jr., 149 Prospect st., Passaic
Hayman, Irving R., 681 Broadway, Paterson
Hochman, Alex, 260 Hamilton av., Paterson
Hollingsworth, H. Hale, 86 First st., Clifton
Holmes, Thomas J. E., 151 Fair st., Paterson
Holster, Stephen G., 951 Madison av., Paterson
Holt, Herman H., 576 Broadway, Paterson
Hughes, J. Vernon, P. O. Box 454, Passaic
Ianacone, John A., 310 Fifth av., Paterson
Iraggi, James V., 53 Passaic av., Passaic
Izenberg, David, 555 E. 29th st., Paterson
Jaffe, Hyman, 149 Broadway, Passaic
Jahn, Albert G., 657 Main av., Passaic
Jani, Frank F., 297 Lexington av., Passaic
Jehl, Joseph R., 59 Harding av., Clifton
Joelson, Dora, 485 Park av., Paterson
Joelson, Morris S., 577 Broadway, Paterson
Joffe, Philip M., 556 E. 28th st., Paterson
Joffe, Sidney H., 556 E. 28th st., Paterson
Johnsen, Sigurd W., 149 Prospect st., Passaic
Joseph, Morris, 271 Lexington av., Passaie
Kaletkowski, Marion F., 4 Englewood rd., Clifton
Kassel, Mortimer H., 34 Elmwood et., East Paterson
Katz, Harry, 494 Park av., Paterson
Katz, Herbert I., 278 Park av., Paterson
Keating, Charles A., 177 Ellison st., Paterson
Keating, Joseph M., 657 Main av., Passaic
Keller, Michael L., 673 E. 27th st., Paterson
Kelley, Ray H., 72 Wyekoff av., Midland Park
Kennedy, A. Andrew, 123 Hadley av., Clifton
Kennedy, Eugene T., 413 Wanaque av.,PomptonLks.
Keppler, Charles, Jr., 723 Allwood rd., Clifton
Kim, Gay B., 703 Main st., Paterson
Kinney, Burton O., 41 Lincoln av., Little Falls
Kleiner, Samuel, 162 Hamilton av., Paterson
Kleinmann, Eberhart H., 560 Broadway, Paterson
Klughaupt, Dorothy K., 257 Boulevard, Passaic
Koenig, Bertram, 349 Broadway, Paterson
Koerber, George, 136 Prospect st., Passaic
Korman, Arnold, 726 Broadway, Paterson
Kovaleski, Walter A., 77 Market st., Passaic
Kovin, Abraham, 123 Lexington av., Passaic
Krakower, Alvin H., 528 E. 29th st., Paterson
Krugman, Benjamin M., 438 Park av., Paterson
Laauwe, Harold W., 360 Park av., Paterson
Landaw, Louis, 631 E. 26th st., Paterson
Lang, Richard E., 463 Passaic av., Passaic
Lawless, Edward T., 47 Hawthorne av., Bloomfield
Lawrence, Arthur C.,306 Brown's Lane,St.Mat'ws,Ky.
Lawrence, Elias D., 428 Park av., Paterson
Leach, John E., 17 Bancroft pl., Fair Lawn
Lee, Frederick P., 606 E. 27th st., Paterson
Legg, George E., 666 Broadway, Paterson
Leibovitz, Altan C., 261 Lexington av., Passaic
Lemay, Albert T., 532 14th av., Paterson
Levine, David B., 647 Broadway, Paterson
LeVine, Israel, 215 Broadway, Paterson
Levine, Sidney C., 459 Park av., Paterson
Levinsohn, Sandor A., 656 East 29th st., Paterson
Levy, David, 268 Park av., Paterson
Levy, Herman, 219 Lexington av., Passaic
Liana, Stephen M., 456 Park av., Paterson
Lima, John G., 292 Broadway, Paterson
Linares, A. Carfi, 208 Market st., Paterson
Lipton, Louis, 67 Passaie av., Passaic
Lobsenz, Nathan P., 294 Broadway, Paterson
Lomauro, James R., 184 Lexington av., Passaie
London, Jules R., 340 Paulison av., Passaic
London, Leslie, 120 Lexington av., Passaic
Low, Donald B., 529 Broadway, Paterson
Lucent, S. Bell, 2 First av., Little Falls
Luksteid, Casimir J., 326 Park av., Paterson
Mabee, John R., 24 Center av., Little Falls
MacGahan, William H., 1 Main st., Butler
MacGregor, Allan W., 379 Ellison st., Paterson
MacGuffie, Robert N., 657 Main av., Passaic
Mackler, Meyer E., 627 E. 24th st., Paterson
Maclay, Joseph A., 239 Broadway, Paterson
Maffongelli, Joseph A., 494 River st., Paterson
Magnes, Max, 555 15th av., Paterson
Manly, Thomas E., 390 Park av., Paterson
Manrodt, Kurt, Jr., Pompton Plains
Manzione, Frank A., 500 Union av., Paterson
Marini, Dominick, 40 Henry st., Passaic
Markel, Albert G., 450 Park av., Paterson
Markowitz, Louis, 380 Park av., Paterson
Marrocco, William A., 445 Park av., Paterson
Martin, Theodore, 577 Lincoln av., Glen Rock
Masucci, Alberico, 128 Carroll st., Paterson
Matthews, Leonard M., 655 Main av., Passaic
McBride, Andrew F., Jr., 655 Broadway, Paterson
McCarthy, George L., 506 Union av., Paterson
McCue, John B., 118 Lenox av., Pompton Lakes
McDonald, Richard J., 80 Park av., Paterson
McPherson, Malcolm E., 141Diam'd Br.av.,H'wth'rne
Meer, Nadhim E., 338 Park av., Paterson
Meier, William U., 1062 Ringwood av., Haskell
Meloney, Lester F., 156 Second st., Clifton
Meneve, Alfred D., 373 Broadway, Paterson
Meyers, Francis R., 604 E. 28th st., Paterson
Michelson, Henry, 675 E. 24th st., Paterson
Missonellie, William, 404 Lafayette av., Hawthorne
Mitchell, Charles R., 311 Broadway, Paterson
Monaloy, Morris A., 414 Passaic av., Passaic
Morici, Theodore, 80 Howe av., Passaic
Morrill, James P., Jr., 310 Broadway, Paterson
Morrow, J. Lloyd, 585 Main av., Passaic
Moscoe, Harry A., 320 Broadway, Paterson
Mott, Joseph E., 426 Park av., Paterson
Murn, Charles J., 48 Smith st., Paterson
Nemirow, Martin, 234 Lexington av., Passaic
Nesbitt, Elizabeth, N. Jersey Tr'n'g Sch'l,LittleFalls
Norris, Alfred W., 136 N. Van Dien av., Ridgewood
Norval, William A., General Delivery, Paterson
Notkin, Meyer, 559 Broadway, Paterson
Nussbaum, Nathan, 237 Lakeview av., Clifton
O'Brian, Dennis M., 154 Lexington av., Passaic
O'Brian, Jeremiah H., 661 Main av., Passaic
Offenkrantz, Freder'k M., St. Joseph's Hosp., Pat's'n
Ogden, Michael A., 20 Grove st., Passaic
Okin, Irving, 165 Passaic av., Passaic
Opper, Philip, 606 E. 26th st., Paterson
Oram, Joseph H., 495 Broadway, Paterson
Ozier, Charles W., 223 Autumn st., Passaic
Palma, Nicholas, 116 17th av., Paterson
Palmer, Francis R., 220 Lexington av., Passaic
Palmeri, Anthony, 111 Chelsea rd., Clifton
Paris, William, 518 E. 25th st., Paterson

Pasternack, Elroy, 71 Lexington av., Passaic
Patella, Fulvio, 324 Broadway, Paterson
Pearlman, Saul J., 579 Broadway, Paterson
Pernetti, Anthony M., 400 Park av., Paterson
Pfeffer, Burton B., Veterans Administration, Lyons
Phelps, James E., 203 Park av., Paterson
Piasecki, Chester A., 585 E. 29th st., Paterson
Piller, Jacob, 213 Broadway, Paterson
Pink, Solomon H., 21 High st., Butler
Plinke, Fritz W., 663 Main av., Passaic
Polizzotti, Joseph L., 193 Park av., Paterson
Pollock, Theodore, 64 Grove st., Passaic
Polowe, David, 555 E. 27th st., Paterson
Provisor, Benjamin, 271 Lexington av., Passaic
Raab, Michael, 250 Lexington av., Passaic
Radest, Louis J., 347 Broadway, Paterson
Randazzo, Anton P., 82 Prospect st., Passaic
Rauschenbach, Paul E., Jr., 612 E. 29th st., Paterson
Reading, H. Eugene, 535 E. 29th st., Paterson
Reeves, Ernest, 195 Lexington av., Passaic
Reilly, Thomas F., 127 Union av., Clifton
Reinhorn, Abraham J., 597 E. 27th st., Paterson
Reinkraut, Arthur D., 175 Broadway, Passaic
Ressetar, Michael, 455 Lexington av., Clifton
Riccobono, Cosmo S., 334 Park av., Paterson
Rinzler, Harry G., 127 Van Houten av., Passaic
Ritter, John J., Box 86, Plainfield, Mass.
Robertson, Eugene V., 17 Arlington av., Hawthorne
Roemer, Jacob, 591 E. 27th st., Paterson
Rogers, James A., 274 Carroll st., Paterson
Romano, Michael J., 2 Arlington pl., Radburn
Ross, Peter W., 655 Main av., Passaic
Roy, Joseph N., 95 17th av., Paterson
RuBacky, Joseph F. A., 61 Passaic av., Passaic
Ruocco, William B., 416 River st., Paterson
Russell, Charles B., 119 Hamilton av., Paterson
Sabarese, Theodore C., 122 Marsellus pl., Garfield
Saco, Louis S., 922 Main st., Paterson
Saffron, Morris H., 292 Paulison av., Passaic
Sala, Aldo W., 172 Randolph av., Clifton
Salerno, Louis, 973 Van Houten av., Clifton
Salter, Kent, Valley View Sana., Paterson
Salzman, Nathan, 714 Broadway, Paterson
Sanfacon, Thomas A., 340 Park av., Paterson
Santangelo, Emil L., 313 18th av., Paterson
Santoro, Anthony, 45 Ward st., Paterson
Sarokhan, Joseph, 771 Madison av., Paterson
Schafer, Marguerite A., 298 D'mondBr.av.,H'wth'rne
Schefrin, Alexander E., 235 Lexington av., Passaic
Schleifer, Arnold, 10-04 River rd., Fair Lawn
Schlossberg, Ezra, 175 Broadway, Passaic
Schnee, Isadore M., 586 E. 25th st., Paterson
Schubert, Roy R., 466 Park av., Paterson
Schultz, Augustin M., 379 Union av., Paterson
Schultz, Irving A., 31-11 Broadway, Warren Point
Schwartz, Jacob R., P. O. Box 305, Fair Lawn
Schwartz, Leo, 301 Harrison st., Passaic
Schwartz, William, 224 Lexington av., Passaic
Schwartzberg, Frederick I., 522 Broadway, Paterson
Schwarz, Julianna L., 115 Prospect st., Passaic
Scielzo, Nicholas F., 369 Park av., Paterson
Scillieri, John, 660 Broadway, Paterson
Scovern, Louis, 112 Westervelt pl., Passaic
Scribner, Chas. H., R.F.D.1, Hamb'g Tnpk.,Pat'ers'n
Shapiro, David, 542 Broadway, Paterson
Shapiro, Joseph S., 375 Broadway, Paterson
Shapiro, Louis G., 375 Broadway, Paterson
Shechtman, Abraham, 37 Grove st., Passaic
Sheft, Matthew J., 112 Lexington av., Passaic
Shinefeld, Maurice A., 669 Broadway, Paterson
Shipman, Meyer P., 575 Broadway, Paterson
Shulman, Abraham, 528 E. 29th st., Paterson
Sicillano, Thomas, 6 Clinton av., Clifton
Silver, Michael W., 718 E. 25th st., Paterson
Silverman, Irving A., 164 Randolph av., Clifton
Simkin, Abraham, 232 Broadway, Passaic
Simon, Philip H., 174 Columbia av., Passaic
Siss, Alfred A., 198 Haledon av., Prospect Park
Slaff, Florence, 16 Grove st., Passaic
Sloan, Samuel L., 182 Belmont av., Paterson
Small, Louis, 101 Prospect st., Passaic
Smith, Elroy W., 309 E. DeLido dr., Miami B'ch,Fla.
Smith, Leon A., 655 Main av., Passaic
Smolev, Joseph M., 585 Main av., Passaic
Sobel, I. Jerome, 136 Broadway, Passaic
Spinnler, Henry R., 242 Haledon av., Prospect Park
Stark, Jacob, 645 Broadway, Paterson
Stein, Harold M., 227 W. Broadway, Paterson
Stein, Harriet N., 620 Ridge rd., Lyndhurst
Stier, Howard W., 164 Jefferson st., Passaic
Stokes, James S., 32 Main st., Little Falls
Stoltz, Raymond R., 23 Passaic av., Passaic
Stouter, Francis L., 661 E. 18th st., Paterson
Strully, Leonard V., 660 Broadway, Paterson
Sucoff, Moses C., 158 Hamilton av., Passaic
Sullivan, William M., Jr., 43 Passaic av., Passaic
Surgent, George W., 1074 Van Houten av., Clifton
Szymanski, John J., 616 Main av., Passaic
Taber, Leslie R., 292 Broadway, Paterson
Tarta, Ciro S., 654 E. 18th st., Paterson
Teichholz, Max H., 19 Meade av., Passaic
Tell, M. Edward, 249 Lexington av., Passaic
Thomas, Irene O., 350 Lafayette av., Hawthorne
Thomas, Leon H. S., 631 E. 22nd st., Paterson
Thompson, Edward C., 373 Park av., Paterson
Thompson, Walter A., 714 Ackerman av., Glen Rock
Thorne, William P., 254 Main st., Butler
Thron, Leopold E., 586 E. 29th st., Paterson
Todd, Francis H., 83 Auburn st., Paterson
Tomkins, William, 105 Fairmount rd., Ridgewood
Tweddel, George K., 239 Broadway, Paterson
Udinsky, Hyman J., 57 Passaic av., Passaic
Vanderbeck, James J., 123 Prospect st., Ridgewood
Vanderbeek, Andrew B., 174 Broadway, Paterson
Vanderbeek, Frank B., 683 E. 27th st., Paterson
Vander Clock, Cornelius, 178 Gregory av., Passaic
Van Eerde, Albert, 339 Lafayette av., Hawthorne
Van Schott, Gerard J., Jr., 245 Lex'gton av., Passaic
Van Winkle, John S., 297 Broadway, Paterson
Vermeulen, Abram, 344 Haledon av., Prospect Park
Vernaglia, Anthony P., 418 Lincoln av., Hawthorne
Vosburgh, Fred, 663 Main av., Passaic
Vreeland, Ralph J., 278 McKinley pl., Ridgewood
Walker, Harold G., Everett av., Wyckoff
Wallace, Marc J., 165 Lakeview av., Clifton
Walton, Gordon G., 575 E. 28th st., Paterson
Warburton, Jack C., 333 Park av., Paterson
Warren, David E., 48 Rutgers pl., Passaic
Warren, Earl L., Box 1738, Paterson
Warren, Jacob, 308 18th av., Paterson
Wassing, Hans, 695 Broadway, Paterson
Weiner, Aaron, 660 Broadway, Paterson
Weinert, Henry V., 128 Market st., Passaic
Weintraub, William L., 400 Broadway, Paterson
Weisman, Stephen L., 526 Broadway, Paterson
Westerhoff, Peter D., 51 Highland av., Midland Park
White, Richard E., Grandview av., Wyckoff
Williams, Hiram, P. O. Box 272, Passaic
Winters, Walter M., 288 Broadway, Paterson
Wishnack, Meyer, 318 Broadway, Paterson
Wolf, Erich, 43 Grove st., Passaic
Wolf, Israel J., 231 East 31st st., Paterson
Wolfson, Harry, 356 Park av., Paterson
Wry, Dean A., 234 Dayton av., Clifton
Yachnin, Samuel C., 127 Prospect st., Passaic
Yager, J. Allen, 420 Broadway, Paterson
Yates, John S., 414 Ellison st., Paterson
Yeaw, Ralph C., 310 Broadway, Paterson

Yolken, Harry, 246 E. 31st st., Paterson
Yorke, Benjamin, 908 Main st., Paterson
Zalewski, Irene J., 181 Paulison av., Passaic
Zick, Clara U., 60 Highland rd., Glen Rock
Zigarelli, Joseph F., 275 E. 18th st., Paterson
Zuckerman, David E., 568 Broadway, Paterson
Zuckerman, Louis, 568 Broadway, Paterson

ASSOCIATE MEMBERS

Ambrose, Francis, 445 15th av., Paterson
Beim, Norbert, 660 Broadway, Paterson
Born, Joseph, 457 East 28th st., Paterson
Brawer, Jerome, 425 Park av., Paterson
Buklad, Henry P., 441 Broadway, Passaic
Burchell, Frank H., 108 Preakness av., Paterson
Canaan, Robert, 12-18 River rd., Fair Lawn
Ciccone, Roy, 57 Passaic av., Passaic
De Dominicis, Frank A., 811 E. 22nd st., Paterson
Dirr, John P., 785 Main av., Clifton
Garzieri, Anthony, 444 Totowa rd., Totowa
Gerson, Stanley, 480 Park av., Paterson
Herman, Isadore, 119 Quincy st., Passaic
Insolera, John A., 388 Park av., Paterson
Jurewicz, Stanley T., 290 17th av., Paterson
Kerr, Andrew D., Jr., 19 Lincoln av., Clifton
Kremer, Leonard, 707 Broadway, Paterson
Kuhn, Richard E., 39 Fernwood ct., Clifton
Kulick, Morton, 731 14th av., Paterson
Nuzzolo, Charles A., 13 Lee pl., Paterson
Pasquariello, Peter, 979 E. 23rd st., Paterson
Pinck, Bernard, 161 Lexington av., Passaic
Rasin, Carl, 158 Lexington av., Passaic
Rizzo, Ettore G., 184 Redwood av., Paterson
Rosenberg, Marvin, 174 Gregory av., Passaic
Rothenberg, Friedrich, 395 Ellison st., Paterson
Scillieri, Frank, 1072 Madison av., Paterson
Selikoff, Irving, 707 Broadway, Paterson
Sporer, Andrew, 707 Broadway, Paterson
Szafir, Paul, 250 Van Houten st., Paterson
Tarchiani, Lucius S., 494 River st., Paterson
Taylor, Halley B., Jr., 221 Hamilton av., Paterson
Varhol, Joseph G., 436 Clinton av., Clifton

COURTESY MEMBERS

Larkey, Irving G., Passaic
Lewin, Michael L., Paterson
Trilling, Leonard J., Paterson

HONORARY MEMBERS

Bullen, Victor E., Paterson
Crounse, David R., Passaic
Duncan, Owsley B., Paterson
Flitcroft, William, Waukesha, Wisconsin
Maclay, Joseph A., Paterson
Norval, William A., Paterson
Ritter, John J., Plainfield, Massachusetts
Russell, Charles B., Paterson
Scribner, Charles H., Paterson
Todd, Francis H., Paterson
Vanderbeek, Andrew B., Paterson
Walton, Gordon G., Paterson
Yates, John S., Paterson

SALEM COUNTY (17)

Society organized May 4, 1880. Meets on the third Friday of each month, September to May, inclusive. Annual Meeting in April. Social Meeting in May.

ACTIVE MEMBERS

Bramble, Halsey S., Front & Chestnut sts., Elmer
Chesler, Maurice, 124 W. Broadway, Salem
Cox, J. Robert, Mullica Hill
Davison, C. Spencer, 7 Chestnut st., Salem
Davison, Wilbur S., 13 N. Broadway, Pennsville
Dunn, John S., 75 Market st., Salem
Evans, Edgar E., 12 Ziegler Tract, Penns Grove
Fleming, Charles L., 42 W. Main st., Penns Grove
Green, David W., 69 Market st., Salem
Hilliard, William T., 105 Market st., Salem
Hummel, Lee C., 109 W. Broadway, Salem
Jonas, August, 328 E. Broadway, Salem
Lipkin, Isadore, 157 W. Main st., Penns Grove
Mackes, Claude B., 48 N. Main st., Woodstown
Mason, Alvin S., 26 Olive st., Salem
Miller, William H., 7 Dickinson st., Woodstown
Neander, David G., 57 Chestnut st., Salem
Perry, Frank L., East av., Woodstown
Silverman, R. Louis, 21 W. Main st., Penns Grove
Suter, Harry F., 49 W. Main st., Penns Grove
Thomas, Claude W., 28 East av., Woodstown
Wetherhold, John M., 20 Ziegler Tract, Penns Grove
Zappala, John, 47 W. Main st., Penns Grove

SOMERSET COUNTY (18)

Society organized May 21, 1816. Meets on second Thursday evening of each month except July, August and September. Annual Meeting in June. Dinner Meeting in October.

ACTIVE MEMBERS

Albrecht, William J., 46 Grove st., Somerville
Allegrante, Anthony J., Washington Val. rd., Martinsv'e
Ambrose, Robert R., 304 E. High st., Bound Brook
Barbour, George E., 118 W. High st., Somerville
Borow, Henry, 507 Church st., Bound Brook
Borow, Louis S., 507 Church st., Bound Brook
Brittain, Elmore G., 4 E. High st., Bound Brook
Cameron, Albert, 10837 Sea Lane, Philadelphia, Pa.

Carlucci, Angelo M., N. J. State Village, Skillman
Case, Clarence E., Jr., 254 Altamount pl., Somerville
Chase, Anthony V., 654 Lincoln av., Manville
Cook, Caroline S., 27 E. Cliff st., Somerville
Cook, Homer E., 27 E. Cliff st., Somerville
Cooley, Justus H., II, 150 W. High st., Somerville
Craig, Henry A., 315 William st., Somerville
Day, Hayward F., 92 Deur st., Plainfield
Douglass, William C., 15 Olcott av., Bernardsville
Dresel, Irmgard, Mine Brook rd., Far Hills
Edelberg, Sidney S., 403 E. High st., Bound Brook
Ely, Lancelot, 128 W. High st., Somerville
Falcone, Nicholas A., 68 Watchung av., N. Plainfield
Field, Frank L., Far Hills
Flint, Edgar T., 44 E. Somerset st., Raritan
Fritts, Lewis C., 118 West End av., Somerville
Galgoczy, Julius, Manville
Gentile, Ernest R., 125 Hamilton st., Bound Brook
Glass, George A., 282 E. Main st., Somerville
Gray, W. Burritt, 121 Somerset st., N. Plainfield
Greenberg, George A., 195 W. High st., Somerville
Guertin, Diomede, N. J. State Village, Skillman
Hartmann, Edmund M., 122 Midway av., Fanwood
Hawkins, W. B., Veterans Administration, Lyons
Hegeman, Runkle F., 161 W. High st., Somerville
Hird, Emerson F., 118 E. Maple av., Bound Brook
Hochheimer, Arthur, 417 Somerset st., Bound Brook
Husted, Samuel H., Neshanic Station
Hyer, Godfrey S., 199 W. High st., Somervilie
Jones, William F., N. Bridge st., Somerville
Kay, Clarence R., Main st., Peapack
Kiompus, Irving, 301 E. High st., Bound Brook
Knight, Augustus S., Far Hills
Levy, Abram, 1401 Plainfield av., South Plainfield
Liddell, Raymond N., Leonardo
Mangelsdorff, Arthur, 707 W. Eighth st., Plainfield
Marcus, Bernard, 6 S. Clark av., Somerville
McKinley, C. Scott, Bakelite Corp., Bound Brook
Misko, Albert, 117 Westervelt av., N. Plainfield
Morris, Nathan, 607 E. Second st., Plainfield
Pauly, Arthur N., 297 W. Summit st., Somerville
Pauncz, A., Veterans Administration, Lyons
Pitman, Mason W. H., 17 Ross st., Somerville
Pogoloff, Samuel H., 68 N. First av., Manville
Reaie, Nicholas P., Brooks blvd., Manviile
Renner, Clara C., Blawenburg
Roecker, Roland D., Veterans Administration, Lyons
Rossi, Bartolomeo, 564 Central av., Bound Brook
Rossi, Gene, 148 W. Franklin st., Bound Brook
Russo, Dominic T., 51 E. Somerset st., Raritan
Sanford, Marcus E., 27 Ross st., Somerville
Sargent, Eva R., 121 Myrtle av., North Plainfield
Saukimas, John, Calco Chemical Co., Bound Brook
Spaldo, John L., 32 Grove st., Somerville
Stolow, Alan A. J., 219 W. Summit st., Somerville
Tolomeo, Martin E., 5 E. High st., Bound Brook
Waliach, Bernard, 74 Watchung av., N. Plainfield
Weitz, Paul, Veterans Administration, Lyons
Wender, Harold, 103 Clinton st., So. Bound Brook
Wolfsie, Jacob H., American Cyanamid Co., Linden
Young, James L., 68 Mountain av., Somerville

ASSOCIATE MEMBER

Foster, H., Veterans Administration, Lyons

SUSSEX COUNTY (19)

Society organized August 22, 1829. Regular meetings in February, May, September and December at time, place and date designated by President and Secretary.

ACTIVE MEMBERS

Aitken, Herbert M., Ogdensburg
Bergmann, Ewald H., 44 Bank st., Sussex
Boyd, William B., Jr., N. J. Zinc Co., Franklin
Burn, Victor E., 27 Trinity st., Newton
Caleca, Jack J., Andover
Cartisser, Joseph J., Stanhope
Catlett, George F., Newton
Coleman, Joseph G., Hamburg
Drake, Leo B., 47 Main st., Franklin
Eddy, Lester R., 40 Bank st., Sussex
Hill, Dean F., Sussex
Johnson, George F., Branchville
Kirschner, Martin I., Vernon
Landes, Edwin W., Stillwater
Longnecker, John E., Jr., Sparta
Lushear, Frank H., Branchville
McCali, Jesse, 9 Linwood av., Newton
McVeigh, Charles J. D., Netcong
Morrison, Frederick H., 61 High st., Newton
Nestor, John, 36 Halsted st., Newton
Peiiet, Thomas L., Hamburg
Piampiano, John, 27 Vernon av., Hamburg
Roy, Bert W., 25 Hamburg av., Sussex
Schmidt, Clifford M., 81 Main st., Newton
Scott, Frederick J., 1 Oak st., Franklin
Spencer, James H., Jr., Newton
Spurgeon, Dorsett L., 19 Church st., Newton
Stewart, Katherine E., Railroad av., Ogdensburg
Vermes, Leslie, 380 Rutherford av., Franklin
Weiser, Edward H., 1 E. Main st., Sussex
Weinstein, Robert A., 214 Spring st., Newton

UNION COUNTY (20)

Society organized June 7, 1869. Meets on second Wednesday of September, November, January, March, April, and May. Annual Meeting in April.

ACTIVE MEMBERS

Abel, Henri E., 339 Union av., Elizabeth
Abramson, Solomon, 1181 Jaques av., Rahway
Ackerman, Arthur F., 129 Summit av., Summit
Anson, Leon J., 400 Center st., Garwood
Apfelbaum, Frederick M., 17 N. 10th st., Kenilworth
Armstrong, Lorrimer B., 121 S. Euclid av., Westfield
Arthur, Frances H., 138 Westfield av., Elizabeth
Austin, Thomas R., 19 Holly st., Cranford

Axinn, Charles, 146 W. Gibbons st., Linden
Babbitt, Hugh M., Jr., 950 Park av., Plainfield
Baker, Raymond D., 52 De Forest av., Summit
Balsbaugh, Edward F., 440 E. Broad st., Westfield
Banker, George T., 655 Magie av., Elizabeth
Barberio, A. Arthur, 1337 Orange av., Union
Baron, Leo E., 26 Prospect pl., North Plainfield
Baruch, Hilde, 202 Stiles st., Elizabeth
Baruch, Rudolf J., 202 Stiles st., Elizabeth
Battaglia, Richard S., 323 Third av., Roselle
Bechet, Paul E., 1364 North av., Elizabeth
Beisler, Lawrence G., 1528 N. Broad st., Hillside
Belle, Louis, 948 Madison av., Elizabeth
Bender, Dorothea A., 61 DeHart pl., Elizabeth
Bensley, Maynard G., 129 Summit av., Summit
Berenson, Samuel J., 1012 E. Jersey st., Elizabeth
Berger, Harold R., 250 Elizabeth av., Elizabeth
Berman, Leonard M., 128 Summit av., Summit
Berman, Sol, 351 Rahway av., Elizabeth
Berry, C. Hartley, 129 Summit av., Summit
Biber, David, 900 Stuyvesant av., Union
Birrell, Russell G., 56 Church st., Toronto 1, Canada
Black, Max S., 1320 St. George av., Linden
Blair, Thomas D., 919 Park av., Plainfield
Blatt, David, 737 Jefferson av., Elizabeth
Bloch, Harry, 613 N. Broad st., Elizabeth
Blumberg, Jack, 504 Westminster av., Elizabeth
Blythe, Rowland P., 30 Springfield av., Cranford
Boehm, Herbert, 804 E. Jersey st., Elizabeth
Bolanowski, Kasimier J., 145 Marshall st., Elizabeth
Bomar, Wirrion L., 310 Plainfield av., Plainfield
Booth, Walter S., 744 Rahway av., Elizabeth
Bourns, Edward G., 203 S. Euclid av., Westfield
Bowles, Harry H., 36 Woodland av., Summit
Boyd, Robert P., 210 Martine av., S., Fanwood
Boyer, Paul K., 129 Summit av., Summit
Boyes, James G., 1326 Chetwynd av., Plainfield
Braunwarth, Robert J., 555 S. Broad st., Elizabeth
Breslow, Alexander E., 930 Pierpont st., Rahway
Brethwaite, Samuel H., Jr., 129 Summit av., Summit
Brock, Howard F., 417 W. Broad st., Westfield
Brokaw, Christopher A., 1405 North av., Elizabeth
Brown, Frank H., Jr., 327 Chestnut st., Roselle Park
Brown, L. Greeley, 173 Madison av., Elizabeth
Brown, William H., 501 First av., Elizabeth
Bruno, Anthony, 1092 Elizabeth ay., Elizabeth
Buchanan, Robert W., 129 Summit av., Summit
Buffey, Walter H., McGuire Gen. Hosp., Richm'd,Va.
Burritt, Norman W., 30 Beechwood rd., Summit
Butenas, Joseph J., 300 First av., Elizabeth
Callahan, Edward J., 124 St. Paul st., Westfield
Cannis, John P., 1019 Park av., Plainfield
Canright, Cyril M., 34 Springfield av., Cranford
Cantini, Raphael S., 727 Watchung av., Plainfield
Card, Charles F., 144 W. Milton av., Rahway
Cardinale, Pasquale F., 654 E. Jersey st., Elizabeth
Carlin, Edward J. M., 1423 Irving st., Rahway
Carlisle, J. Mallory, 550 Hillcrest av., Westfield
Carpenter, Cedric C., 97 Hobart av., Summit
Carroll, Bruce J., 469 W. Front st., Plainfield
Carsley, Sidney H., 19 Holly st., Cranford
Casey, Robert B., 51 W. Milton av., Rahway
Casilli, Arturo R., 618 Newark av., Elizabeth
Castaldo, Neil, 103 Lincoln av., E., Cranford
Chaiken, Louis H., P. O. Box 51, Elizabeth
Chapman, Otis P., 125 Broad st., Elizabeth
Childers, Robert J., 604 Park av., Plainfield
Chodosh, Maurice A., 606 Roosevelt av., Carteret
Coe, Edward M., 217 Holly st., Cranford
Cohen, Harry X., 1267 Stuyvesant av., Union
Cole, Walter H., Jr., 1060 E. Jersey st., Elizabeth
Comunale, Anthony R., 1709 Irving st., Rahway
Connolly, Joseph A., 11 Coddington av., N. Plainfield
Conover, Elizabeth, 129 Summit av., Summit
Constad, Arnold N., 944 Stuyvesant av., Union
Conway, James V., 428 Elmora av., Elizabeth
Coplin, George J., 528 E. Jersey st., Elizabeth
Corbusier, Harold D., 612 Park av., Plainfield
Cox, William T. R., 345 S. Broad st., Elizabeth
Crabtree, Loren H., 505 Jersey av., Elizabeth
Crane, Norman T., 1025 Sleepy Hollow lane,Plainf'd
Cronin, Francis J., 730 South st., Elizabeth
Dalberg, Walter, 500 Cherry st., Elizabeth
Dallam, Lloyd A., 1115 E. Grand st., Elizabeth
Darlington, Charles G., 802 Belvidere av., Plainfield
Davidson, E. Norwell, 102 East Elm st., Linden
Davis, F. Cleveland, 129 Summit av., Summit
Davis, Stanton H., 212 E. Seventh st., Plainfield
Day, Willis B., 407 E. Seventh st., Plainfield
DeCesare, Ferdinand J., 500 Walnut st., RosellePark
Decker, Charles T., 275 Orchard st., Westfield
Deehl, Seymour R., 1026 E. Jersey st., Elizabeth
Demarest, Gerald B., 505 E. Broad st., Westfield
Demy, Nicholas G., 912 Prospect av., Plainfield
Dengler, Henry P., 260 Morris av., Springfield
Deutsch, Nathan S., 223 E. Fifth st., Plainfield
Diamond, J. George, 512 W. Front st., Plainfield
Diefendorf, Herbert W., 129 Summt av., Summit
Dobson, Clarence D., 742 Greenwood rd., Union
Doggett, E. Hugh, 805 Park av., Plainfield
Doherty, William, 830 N. Wood av., Linden
Dolsky, Irving, 509 N. Wood av., Linden
duBusc, L. C. Victor, 399 Westfield av., Elizabeth
Dudley, Henry G., 222 Sylvania pl., Westfield
Dunn, H. Irving, 610 Salem av., Elizabeth
Dupuy, Jean G., 850 Jersey av., Elizabeth
Durrah, Fred F., 310 Plainfield av., Plainfield
Dwoyer, Leon C., 420 N. Wood av., Linden
Eason, Samuel W., 48 De Forest av., Summit
Edgar, Malcolm S., 129 Summit av., Summit
Ehrlich, Max, 721 N. Broad st., Elizabeth
Esty, Geoffrey W., 629 E. Broad st., Westfield
Falcone, Albert M., 505 E. Broad st., Westfield
Falconer-Slater, Kath., Four Winds, Kotonah, N. Y.
Feleppa, Edward E., 618 Springfield av., Summit
Ferenchak, Ralph, 219 Martine av., N., Fanwood
Fiedler, Michael J., 2368 S. W. 4th st., Miami, Fla.
Figliolino, Francis, 272 W. Milton av., Rahway
Fink, Stanley J., 221 Chestnut st., Roselle
Fitch, Thomas S. P., 916 Park av., Plainfield
Folsome, Clair E., 1075 Central av., Plainfield
Fort, William B., 147 E. Seventh st., Plainfield
Foster, Frank L., 320 Springfield av., Cranford
Frankel, Theodore H., 600 Crescent av., Plainfield
Franklin, Joseph E., 191 North av., Hillside
Franklin, Lewis J., 149 Jean ter., Union
Freeman, Ray M., 2011 St. Georges av., Rahway
Friedburg, George H., 1108 Anna st., Elizabeth
Friedlander, Aik, 213 Westfield av., Elizabeth
Frohwein, Ida H., 125 Morristown rd., Elizabeth
Gadomski, Casimir F., 331 S. Broad st., Elizabeth
Gallaway, George E., 163 W. Milton av., Rahway
Gannon, Joseph M., 149 Crescent av., Plainfield
Geary, Paul, 909 Park av., Plainfield
Geib, Margaret E., 1277 Clinton pl., Elizabeth
Gelber, Isaac, 712 N. Broad st., Elizabeth
Gerendasy, Julius, 956 E. Jersey st., Elizabeth
Gibb, Alice S., 339 Union av., Elizabeth
Giglio, Alphonsus S. V., 626 Elizabeth av., Elizabeth
Gilpin, Fletcher, 118 North av., W., Cranford
Giocano, Joseph F., 221 Lincoln av., Union
Gittelman, Morton, 879 Newark av., Elizabeth
Glaser, Emanuel, 360 Linden av., Elizabeth
Glass, Benjamin E., 609 Watchung av., Plainfield
Glass, Harry L., 1009 Park av., Plainfield
Glassner, Frank, 308 Chestnut st., Roselle
Golden, William M., 236 W. Milton av., Rahway
Goldfield, Harold H., 225 E. Jersey st., Elizabeth

Goldmacher, Herman B., 113 Elmora av., Elizabeth
Goldstein, Herman H., 318 W. Jersey st., Elizabeth
Gonczy, Edward J., 420 Jersey av., Elizabeth
Goodspeed, William K., Oakwood rd., Watchung
Gordon, Norman W., 121 Third st., Elizabeth
Grant, William E., 1370 Morris av., Union
Greco, Lionel A., Bonnie Burn Sana., Scotch Plains
Greenberg, Max, 29 W. Henry st., Linden
Griesemer, Laurence C., 515 Locust st., Roselle
Griesemer, Z. Lawrence, 1145 E. Jersey st., Elizab'th
Griswold, Merton L., Jr., 947 Park av., Plainfield
Guidi, Guido M., 212 Christine st., Elizabeth
Hackett, Daniel C., 132 S. Euclid av., Westfield
Hall, Ralph A., 505 E. Broad st., Westfield
Hall, Winthrop H., 400 Elm st., Westfield
Hallock, Wilton J., 650 Springfield av., Summit
Hamley, John J., 153 Second st., Elizabeth
Hanrahan, James, 678 N. Broad st., Elizabeth
Hansen, Harry, 916 Park av., Plainfield
Hanson, Carl G., 38 Springfield av., Cranford
Harris, Sidney, 301 W. Fifth st., Roselle
Hawkins, Edward R., 325 Cherry st., Elizabeth
Hely, Charles J.,Jr., 564 Summit av., Westfield
Heminway, Norman L., 174 Summit av., Summit
Herrington, Lee R., 643 E. Broad st., Westfield
Hill, Clarence T., 116 E. Hazelwood av., Rahway
Hipple, Percy L., 118 E. Fifth av., Roselle
Hirsch, Lucien, 160 E. Seventh st., Plainfield
Hnat, Frederick, 565 Newark av., Elizabeth
Hoch, Samuel M., 240 Hillside rd., Elizabeth
Hoffman, Charles A., 302 E. Seventh st., Plainfield
Hoffman, Harry, 805 Park av., Plainfield
Holland, Reuben J., 1026 Chandler av., Linden
Holmes, Grace A., 1077 E. Jersey st., Elizabeth
Holt, Evelyn, 261 Springfield av., Summit
Holtzman, Michael, 734 N. Broad st., Elizabeth
Hopper, Guy R., 147 Elmer st., Westfield
Horoschak, Anne, 974 Park av., Plainfield
Horre, George W. H., 203 W. Jersey st., Elizabeth
Hughes, Frederic J., 706 Park av., Plainfield
Humphrey, Hubert G., 430 Downer st., Westfield
Hunt, Thomas F., 528 Monroe av., Elizabeth
Hurtado, Edward, 763 Audrey dr., Rahway
Hutton, Frederick T., 717 Watchung av., Plainfield
Imbleau, Joseph E. L., 2106 Morris av., Unionville
Jacobs, Alan L., 254 Williamson av., Hillside
Johnson, Harold F., 734 Park av., Plainfield
Jones, Herbert E., 6 Hillside rd., Elizabeth
Jones, Lewis H., 139 E. Grant av., Roselle Park
Judd, Joseph, Jr., 300 Westfield av., Elizabeth
Kandra, Paul H., 153 Mountain av., Westfield
Kapp, Carl G., 440 Westminster av., Elizabeth
Karel, Jack R., 407 Jersey av., Elizabeth
Karnay, Francis, 348 Pine av., Garwood
Karshmer, Ernest E., 420 Wood av., N., Linden
Katz, Theodore, 927 S. Wood av., Linden
Keeney, Cadwell B., 137 Summit av., Summit
Keil, Sigmund S., 1118 St. George av., E., Linden
Kemeny, George, 39 Third st., Elizabeth
Kennedy, John N., 831 Madison av., Plainfield
Kent, Louis R., 1974 St. Georges av., Rahway
Kidd, Ruth W., 1199 Morris av., Union
Klapper, Lester L., 967 Park av., Plainfield
Kloby, John J., 562 Bayway, Elizabeth
Knauer, George, 930 Elizabeth av., Elizabeth
Knight, Richard vanD., 129 Summit av., Summit
Konzelman, Henry J., 65 King st., Hillside
Kramer, Douglas W., 1019 Park av., Plainfield
Krans, Edward S., 920 Park av., Plainfield
Kreutz, Paul J., 363 Union av., Elizabeth
Kuchlewski, Edward J., 224 E. Jersey st., Elizabeth
Kushner, Alexander, 208 W. Milton av., Rahway
Kyle, Ernest I., 205 W. Ninth st., Plainfield
Labow, Joseph J., 757 N. Broad st., Elizabeth
Ladas, George, 305 Cherry st., Elizabeth
Lance, Elton W., 125 W. Milton av., Rahway
Landry, Ernest J., 156 S. Munn av., East Orange
Lane, Milton, 900 Stuyvesant av., Union
Lang, Louis, 947 E. Jersey st., Elizabeth
Langston, Junius T., 521 E. Second st., Plainfield
Larrabee, Callie H., 10 Irving pl., Summit
Lathrop, Frederic W., 909 Park av., Plainfield
Lawrence, William H., 1419 Forrest av.,DeLand,Fla.
Leggett, Lindley H., Jr., 330 E. Broad st., Westfield
Leggett, Thomas H., Jr., 706 Park av., Plainfield
Leone, Peter P., 27 Princeton rd., Elizabeth
Lepree, Joseph A., 371 Morris av., Elizabeth
Lerman, Frederick, 1024 E. Jersey st., Elizabeth
Lerman, Irving, 1024 E. Jersey st., Elizabeth
Lerman, Samuel, 116 Brightside av., Pikesville, Md.
Lewis, Albert, 41 Retford av., Cranford
Lewis, Alexander, 113 E. Milton av., Rahway
Lewis, Robert L., Jr., 636 Westminster av., Elizabeth
Lieberman, David P., 597 Westminster av., Elizab'h
Lieberman, Milton L., 101 Pershing av., Roselle Pk.
Lilien, Milton M., 152 Clark st., Hillside
Linke, James J. P., 245 E. Front st., Plainfield
Livengood, Horace R., 587 Westminster av., Elizab'h
Livingston, Sydney R., 650 W. 7th st., Plainfield
Llull, Gabriel J., 266 Morris av., Springfield
Losada, Camella A., Cathedral Sta. Box 154,N.Y.C.25
Lowell, Milton E., 434 Summit av., Westfield
Lowenberg, Robert I., 74 Hawthorne pl., Summit
Lowenstein, Ernest C., 259 W. Milton av., Rahway
Lufburrow, Charles B., 441 W. Front st., Plainfield
Lyerly, James M., 121 E. Seventh st., Plainfield
Lynch, Edward T., 748 Livingston rd., Elizabeth
Lynch, Michael F., 3 Palisade rd., Elizabeth
MacDonald, Edward O., 719 Locust st., Roselle Park
Mackler, Harry S., 752 N. Broad st., Elizabeth
Maggio, Ross J., 206 Park av., Westfield
Malatesta, Charles S., 1203 Martine av., Plainfield
Mallison, Herbert, 819 Park av., Plainfield
Marone, Carmine R., 752 Newark av., Elizabeth
Maroney, James H., 129 Summit av., Summit
Martin, William E., 110 Claremont pl., Cranford
Marts, George H., 956 Park av., Plainfield
Mastroianni, Frank M., 634 Sherman av., Roselle Pk.
Maurer, Martha E., 153 Mountain av., Westfield
McAlpine, Paul, 129 Summit av., Summit
McCalllon, Wm. H., 722 Westminster av., Elizabeth
McClintock, Elsie, 1439 Maple av., Hillside
McGeary, John A., 610 Salem av., Elizabeth
McGinn, William J., 1913 Westfield av., ScotchPlains
Meeker, John L., 6 De Barry pl., Summit
Meineke, William C., Jr., 820 Chestnut st., Roselle
Mensch, Harvey G., 1117 Mary st., Elizabeth
Merlo, Francis A., 210 Murray st., Elizabeth
Merlo, Francis V., 33 Prince st., Elizabeth
Miller, George M., 288 Elm av., Rahway
Miller, Robert M., 382 Springfield av., Summit
Milligan, Robert S., 42 Elm st., Summit
Milliser, Estelle T., 126 N. Euclid av., Westfield
Mohr, Frank L., 560 Morris av., Summit
Moon, Dabney vonK., 706 Park av., Plainfield
Morris, Karl E., 648 E. Broad st., Westfield
Morris, Thomas M., 505 Park av., Plainfield
Morris, Watson B., 193 Morris av., Springfield
Murphy, Herschel S., 320 Chestnut st., Roselle
Murray, Norman L., 129 Summit av., Summit
Naidorff, Saul A., 421 W. Seventh st., Plainfield
Nelson, Francis B., 275 Orchard st., Westfield
Neumann, Alfred, 432 Washington av., Linden
Nevins, Thomas F., Jr., 105 Linden av., Westfield
Nevius, John K., Jr., 1165 Park av., Plainfield
Newbury, Graham C., 209 Miln st., Cranford
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth
Novello, Joseph A., 641 Second av., Elizabeth

Nussbaum, Joseph, 321 Elmora av., Elizabeth
Obester, Gabriel E., 640 N. Broad st., Elizabeth
O'Brien, Edwin J., Jr., 503 Park av., Plainfield
Oderr, Charles, 121 S. Euclid av., Westfield
Orton, Foster, 196 Elm av., Rahway
Orton, George L., 196 Elm av., Rahway
Orton, Stuart, 196 Elm av., Rahway
Osher, Morris M., 100 Martine av., N., Fanwood
Owen, Philip, 973 Salem rd., Union
Palin, George, 27A Wavecrest av., Winfield
Pearl, Sydney S., 837 Park av., Elizabeth
Peters, Richard C., 963 Park av., Plainfield
Phelan, Walter F., 124 Chilton st., Elizabeth
Pogge, Raymond C., 816 Central st., Plainfield
Pogue, Elbert H., 168 Madison av., Elizabeth
Poleshuck, Rubin, 100 Hollywood av., Hillside
Polk, Charles C., 114 E. Seventh av., Roselle
Pollack, Louis, 2052 Morris av., Union
Pollack, Sol, 1906 Boulevard, Union City
Prazak, Beatrice, 500 Monroe av., Elizabeth
Preminger, Max, State TB Hosp., San Haven, N.Da.
Proudfoot, Perry A., 527 Walnut st., Roselle
Randolph, Andrew J., 1108 Morris st., Roselle
Read, Jessie D., 519 Lenox av., Westfield
Reale, Frank P., 630 E. Second st., Plainfield
Reich, Jerome J., 1500 N. Broad st., Hillside
Reilly, David F., 44 Prince st., Elizabeth
Reiner, Jacob, 811 N. Broad st., Elizabeth
Reiter, Walter A., 50 DeForest av., Summit
Relyea, George M., 129 Summit av., Summit
Repta, Stephen, 2165 Morris av., Union
Robertson, Grace M., 515 W. Seventh st., Plainfield
Rose, Abraham, 326 S. Broad st., Elizabeth
Rosenblatt, Max B., 150 Westfield av., Elizabeth
Rosenstein, Saivel L., 2120 Springfield av., Vauxhall
Rozett, Oscar, 19 Prospect st., Summit
Rubin, David, 200 E. Jersey st., Elizabeth
Rumsey, Wm. L., Jr., 1336 North av., Elizabeth
Runnells, John E., Bonnie Burn San., Scotch Plains
Sadoff, Joseph, 504 Westminster av., Elizabeth
Sagi, Ellen I., 376 Elmora av., Elizabeth
Salvati, Leo H., 275 Orchard st., Westfield
Satulsky, Emanuel M., 737 N. Broad st., Elizabeth
Sauerbrun, Bertram J. L., 681 Newark av., Elizabeth
Scalessa, Mario F. T., 209 Ashland rd., Summit
Schenk, Joseph R., 1177 Park av., Plainfield
Schiller, Edwin, 523 Westfield av., Elizabeth
Schiller, Rosa O., 523 Westfield av., Elizabeth
Schilling, Anthony B., 727 Jefferson av., Elizabeth
Schillinger, Raphael, 1120 Commerce av., Union
Schirmer, William, 1018 N. Broad st., Hillside
Schlein, David, 812 N. Wood av., Linden
Schlichter, Charles H., 517 Madison av., Elizabeth
Schwartz, Samuel H., 916 Park av., Plainfield
Schweizer, Roman G., 36 Summit rd., Elizabeth
Scott, Kenneth H., Jr., 734 Park av., Plainfield
Seidmon, Edward E., 221 W. Seventh st., Plainfield
Sell, Frederick W., 167 W. Emerson av., Rahway
Senerchia, Fred F., Jr., 457 Union av., Elizabeth
Seybold, Arthur D., 1080 Rahway rd., Plainfield
Seymour, George A., 253 Orchard st., Elizabeth
Shangle, Milton A., 34 Prince st., Elizabeth
Shapiro, Max, 414 Elizabeth av., Elizabeth
Sheedy, John J., 121 E. Seventh st., Plainfield
Silverman, Theodore M., 105 Elmora av., Elizabeth
Sims, Richard V., Jr., 31 Morris av., Summit
Singer, Bella, 640 Wyoming av., Elizabeth
Sly, John L., 382 Springfield av., Summit
Snyder, Howard P., 610 Salem av., Elizabeth
Sordillo, Anthony, 1114 Grandview av., Westfield
Speer, Charles A., 19 Holly st., Cranford
Spirito, Michael W., 219 S. Broad st., Elizabeth
Spivack, David, 315 W. Jersey st., Elizabeth
Spivack, Seymour E., 405 Chestnut st., Roselle
Staub, E. Milton, 505 E. Broad st., Westfield
Steele, Stephen, 10 West Gibbons st., Linden
Steffens, Charles T., 612 Park av., Plainfield
Stein, Emil, 607 Park av., Elizabeth
Stein, George H., 640 Wyoming av., Elizabeth
Stein, Isadore, 817 N. Broad st., Elizabeth
Stein, Martin H., 60 Elmora av., Elizabeth
Steinberg, Werner, 35 Gesner st., Linden
Stephenson, Gordon A., 145 Summit av., Summit
Stevenson, G. McKay, 129 Summit av., Summit
Strauss, Clifton J., 51 De Forest av., Summit
Strelinger, Alexander, 650 N. Broad st., Elizabeth
Strom, Abraham, 410 W. Seventh st., Plainfield
Stuart, J. Earle, 552 E. Second st., Plainfield
Stybel, Joseph, 507 Park av., Plainfield
Suffness, Gustave, 970 Park av., Elizabeth
Taranto, Michael, 13 E. Gibbons st., Linden
Tator, Arthur E., 57 DeForest av., Summit
Thompson, Minturn R., 530 W. Broad st., Westfield
Thompson-Bohne, Mildred H., 62 Elm st., Summit
Tidaback, Austin J., 1060 E. Jersey st., Elizabeth
Tidaback, John D., 52 Beauvoir av., Summit
Tolor, Stanley, 405 Westminster av., Elizabeth
Tomlinson, Rolland D., 505 E. Broad st., Westfield
Townsend, Leslie M., 420 Chestnut st., Roselle Park
Trano, Giovanni, 941 E. Jersey st., Elizabeth
Triarsi, Anthony J., 702 Third av., Elizabeth
Tyndall, Alice E., 263 Walnut st., Westfield
Tyndall, Martha W., 263 Walnut st., Westfield
Vinciguerra, Michael, 604 Westminster av., Elizab'h
Vitale, Dominic V., 749 N. Broad st., Elizabeth
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
Vogel, Nathan F., 297 Morris av., Springfield
Wacker, William F., 1224 Salem av., Hillside
Wagner, Richard, 915 Springfield av., N. Providence
Walsh, Ronald J., 338 S. Broad st., Elizabeth
Walsh, Thomas J., 335 S. Broad st., Elizabeth
Ward, Leo J., 137 W. Jersey st., Elizabeth
Webb, Eleanor A., 887 Springfield av., Summit
Wegryn, Louis S., 257 Elizabeth av., Elizabeth
Weigel, Edgar W., 210 W. Jersey st., Elizabeth
Weigel, Elmer P., 727 Watchung av., Plainfield
Weissberg, William W., 253 W. 72nd st., N. Y. C.
Weissman, Meyer T., 1137 E. Jersey st., Elizabeth
Weitz, Abraham, 20 N. 18th st., Kenilworth
Weltchek, Herbert, 439 Jersey av., Elizabeth
Wermer, Paul, 556 Morris av., Summit
Whitken, Albert I., 1056 North av., Elizabeth
Widdowson, William W., Bell Tele. Lab., Mur. Hill
Willetts, Arthur T., 129 Summit av., Summit
Williams, Frank A., 324 W. Jersey st., Elizabeth
Williams, Leonard D., 726 Watchung av., Plainfield
Wolff, Jerome M., 1414 Martine av., Plainfield
Wolgin, Philip L., 445 Elmora av., Elizabeth
Wuester, William O., 238 Exter way, Hillside
Yellin, Charles H., 915 Jersey av., Elizabeth
Yood, Harold S., 401 Grant av., Plainfield
Yorke, Edward T., 1717 N. Wood av., Linden
Young, Franklin C., 120 Summit av., Summit
Young, Ralph A., 842 N. Wood av., Linden
Yuckman, Robert O., 701 Madison av., Elizabeth
Zeltlin, Herman H., 943 N. Wood av., Linden
Zingales, Joseph A., 101 Holly st., Cranford
Zirpolo, Gene A. V., 1128 Bryant st., Rahway

HONORARY MEMBER

Guldi, Guido M., Elizabeth

WARREN COUNTY (21)

Society organized February 15, 1826. Meets on third Tuesday of January, April, July and October, the last being the Annual Meeting.

ACTIVE MEMBERS

Adler, Hubert J., 91 Morris av., Phillipsburg
Baldauf, Herman, Jr., 210 Greenwich st., Belvidere
Bartolini, Frank, 122 Belvidere av., Washington
Bertland, Alexander D., Belvidere av., Washington
Bloom, G. Homer, 674 Hillcrest Blvd., Phillipsburg
Boquist, Walter A., 380 Hudson st., Phillipsburg
Bossard, Harry B., R. D. 2, Phillipsburg
Bostwick, Wallace R., Main st., Blairstown
Brasefield, Edgar N., 218 Chambers st., Phillipsburg
Buchanan, Ralph M. L., 8 Market st., Phillipsburg
Cooper, Ray C., E. Washington av., Washington
Drake, Paul F., 85 Summit av., Phillipsburg
Genninger, Lewis E., 8 Market st., Phillipsburg
Gordon, Frank S., Blairstown
Humbert, Joseph C., Jr., Stewartsville
Jackson, Elmer C., Blair Academy, Blairstown
Kassow, Philip B., North Blvd., Alpha
Kimmel, Seymour S., Oxford
Krausz, Emery, 577 S. Main st., Phillipsburg
Lemmon, Junius M., 137 Belvidere av., Washington
Marlett, Neumann C., 230 Greenwich st., Belvidere
Martin, Francis E., 130 Mansfield st., Belvidere
Michell, George E., 221 High st., Hackettstown
Potter, Charles W., 184 Belvidere av., Washington
Ringe, Charles L., Jr., Blair pl., Blairstown
Shevitz, David M., 212 Grand av., Hackettstown
Shimer, Floyd A., 88 Lewis st., Phillipsburg
Smith, Herman, 306 Bates st., Phillipsburg
Spillane, Timothy H., 379 S. Main st., Phillipsburg
Stone, Russell B., 56 Summit av., Phillipsburg
Szittya, Sandor, S. Main st., Phillipsburg
Varney, William H., 122 Belvidere av., Washington
West, Guernsey F., 109 S. Main st., Phillipsburg
Wolf, Frank A., 494 S. Main st., Phillipsburg
Zdanowicz, Stefan J., 117 Grand av., Hackettstown
Zuck, Arthur C., 22 Broad st., Washington

COURTESY MEMBERS

Freedman, Leon, Easton, Pennsylvania
Skinner, William, Easton, Pennsylvania

MEMBERSHIP SUMMARY

County	Active	Associate
Atlantic	143	9
Bergen	341	19
Burlington	70	..
Camden	230	..
Cape May	38	..
Cumberland	68	..
Essex	1,267	113
Gloucester	52	..
Hudson	531	..
Hunterdon	28	..
Mercer	266	30
Middlesex	185	27
Monmouth	155	13
Morris	139	..
Ocean	34	..
Passaic	439	33
Salem	23	..
Somerset	69	1
Sussex	31	..
Union	442	..
Warren	36	..
	4,587	245

An Alphabetical List of the Members of The Medical Society of New Jersey

COMPILED MARCH 1, 1948

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

A

ACTIVE MEMBERS

Abarbanel, Milton G. (2)
Abbamonte, Louis W. (7)
Abbott, Charles C. (2)
Abel, Arthur R. (7)
Abel, Henri E. (20)
Abey, William J. H. (11)
Abraham, Albert (14)
Abrams, Abram B. (7)
Abrams, Henry (11)
Abramson, Solomon (20)
Achtentuch, Herman (16)
Ackerhalt, Martin J. (16)
Ackerman, Arthur F. (20)
Ackley, David B. (11)
Adelman, Benjamin B. (7)
Adelson, Edward T. (7)
Adler, Fritz F. (16)
Adler, Howard E. (12)
Adler, Hubert J. (21)
Adler, Lydia (12)
Adler, Samuel (13)
Africano, Julius V. (9)
Agayoff, John D. (2)
Agnew, Hobart M. (7)
Agolia, Michael W. (9)
Ainsley, H. Bryson (9)
Aitken, Frank J. (6)
Aitken, Herbert M. (19)
Albano, Edwin H. (7)
Albano, Frank J. (7)
Albano, Joseph (7)
Albert, Perry (11)
Albini, Mario (9)
Albrecht, William J. (18)
Albright, Louis F. (13)
Alcamo, John H. (7)
Alcaro, Joseph A. (14)
Alessi, Alfred A. (2)
Alexander, John W. (7)
Alexander, Samuel (2)
Alexander, Stewart F. (2)
Alexander, Walter G. (7)
Alford, Ralph I. (7)
Allan, James S. (7)
Allar, Ellis H. (1)
Allegrante, Anthony J. (18)
Allen, Arthur A. (16)
Allen, Chester B., Jr. (7)
Allen, Edwin J. (16)
Allen, James M. (16)
Allen, Raymond N. (7)
Alling, Frederic A. (7)
Allman, David B. (1)
Alonzo, Gerard J. (16)
Alpert, Edward (9)
Alpert, Sidney (15)
Alpren, Bernard F. (16)
Alter, Nicholas M. (9)
Altman, Charles D. (7)
Altschul, Frank J. (13)
Amato, Charles P. (4)
Amato, John R. (7)
Ambrose, Anthony (7)
Ambrose, Robert R. (18)
Amdur, Louis A. (9)
Anastor, Herbert C. (6)
Anderson, John F. (12)
Anderson, Reuben M. (2)
Anderson, Richard D. (3)
Anderson, Robert C. (7)
Anderson, William A. (7)
Anderson, William M. (4)
Anderson, Windom E. (7)
Andrews, Albert G. K. (16)
Andrews, Clarence L. (1)
Andrick, Eugene A. (2)
Andrus, David L. (4)
Angelillo, Marc C. (7)
Angell, Emmett D. (16)
Angelo, Joseph A. (9)
Angioletti, Louis V. (2)
Annitto, John E. (9)
Annunziata, Augustine (7)
Anrig, Grace E. (9)
Anson, Leon J. (20)
Anthony, David W. (11)
Antonius, Nicholas A. (7)
Antopol, William A. (7)
Anuario, Charles B. (7)
Apfelbaum, Frederick M. (20)
Apple, Stanley B. (11)
Applebaum, Irving L. (7)
Applestein, Robert (11)
Appleton, Ralph (15)
Appold, George D. (2)
Apter, Abraham H. (16)
Arena, John (9)
Areson, William H. (7)
Aria, Charles J. (9)
Aria, Michael H. (9)
Armstrong, Lorrimer B. (20)
Aronis, Harry R. (11)
Aronoff, Herman L. (9)
Aronoff, Solomon (9)
Aronowitz, Harry T. (9)
Arons, Harry (7)
Aronsohn, Charles M. (16)
Artaserse, George V. (9)
Arthur, Frances H. (20)
Asbell, Nathan (4)
Ash, Arthur F. (9)
Ash, Frank W. (16)
Ash, Samuel (7)
Ashley, Harmon H. (11)
Assante, M. Hugo (4)
Aszody, Paul (7)
Athey, Kenneth L. (4)
Atkinson, James Q. (3)
Atkinson, John M. (14)
Atwood, Edward A. (16)
Audi, Eugene H. (2)
Auerbach, Friedrich (7)
August, Jacob (7)
Auriemma, Michele (9)
Austin, Henry J. (11)
Austin, Thomas R. (20)
Autorino, Ralph R. (7)
Averbach, Jacob (16)
Avery, Philip S. (12)
Axilrod, Maurice H. (1)
Axinn, Charles (20)
Aymar, Dorothy (9)

ASSOCIATE MEMBERS

Alterbaum, George (7)
Ambrose, Francis (16)
Axilrod, Herbert D. (1)

B

ACTIVE MEMBERS

Babbitt, Hugh M., Jr. (20)
Bachmann, William (7)
Bacon, Mary (6)
Bacote, Ernest F. (7)
Baer, Irving (13)
Baeseman, R. Winfield (13)
Bagg, Linus W. (7)
Bahnson, Conrad M. (9)
Bailyn, Emanuel (9)

Baime, Jules E. (7)
Baiocchi, Pascal J. (7)
Baker, Augustus L. (14)
Baker, Augustus L., Jr. (14)
Baker, Banks S. (4)
Baker, Elsworth F. (13)
Baker, Hugh W. (6)
Baker, Maclyn F. (7)
Baker, Maurice E. (4)
Baker, Philip W. (10)
Baker, Raymond D. (20)
Baldauf, Herman, Jr. (21)
Baldini, Charles F., Jr. (9)
Baldwin, Charles H. (1)
Baldwin, John F. (2)
Balis, Samuel B. (7)
Balles, Edward S. (16)
Balogh, William A. (12)
Balsamo, Anthony J. (9)
Balsamo, Joseph J. (7)
Balsbaugh, Edward F. (20)
Balson, Zachary D. B. (7)
Balze, Henry R. (2)
Bambara, Aurelius J. (10)
Banker, George T. (20)
Banta, Raymond E. (2)
Bar, Samuel (13)
Barb, Kirk B. (4)
Barbano, Alfred J. (12)
Barbash, Roslyn H. W. (2)
Barbella, Joseph D. (7)
Barberio, A. Arthur (20)
Barbour, George E. (18)
Barishaw, Samuel B. (9)
Barkhorn, Charles W. (7)
Barkhorn, Henry C. (7)
Barlow, G. Barton (2)
Barlow, John D. (11)
Barnard, Frank G. (7)
Barnes, William J. (2)
Barnett, Lester A. (13)
Barnhardt, Russell A. (12)
Barnshaw, Harold D. (4)
Barolsky, Benjamin (16)
Baron, Herbert A. (2)
Baron, Leo E. (20)
Barone, Francis A. (9)
Barone, Leo J. (16)
Barr, Joseph (16)
Barrett, John E. (7)
Barrett, Joseph F. (7)
Barroway, James N. (4)
Barrows, Victor I. (5)
Barry, R. Grant (11)
Bartlett, Clara K. (1)
Bartolini, Frank (21)
Barton, Amy S. (3)
Baruch, Hilde (20)
Baruch, Rudolf J. (20)
Basralian, Joseph B. (2)
Bass, Rose D. (7)
Bassett, Lavern C. (12)
Bassett, Norman H. (1)
Bassett, Samuel (2)
Battaglia, Albert J. (8)
Battaglia, Richard S. (20)
Baum, Felix (7)
Baum, Lewis F. (7)
Baum, Otto (7)
Baum, Samuel (7)
Bauman, Everett O. (7)
Bauman, Rush C. (7)
Baxt, Sidney J. (16)
Bayer, Eric C. (2)
Bayer, Harold J. (1)
Bayne, Joseph K. (11)
Beairsto, Everett B. (11)
Beall, William T. (8)
Beard, James R., Jr. (14)
Beatty, Hannah J. (10)
Beaver, Jennie D. (14)
Bechet, Paul E. (20)
Becker, C. Frederick (4)
Becker, Frank F. (16)
Becker, George L. (16)
Becker, Leo V. (16)
Becker, Martin (7)
Becker, Marvin C. (7)
Becker, Sidney D. (12)
Bednarz, Stephen (2)
Bedrick, John J. (9)
Beer, Sanel (7)
Behrens, Herman H. E. (9)
Beideman, Casper M. (4)
Beir, Ily R. (1)
Beirne, Donald P. (7)
Beisler, Lawrence G. (20)
Bekampis, Eugene H. (4)
Belafsky, Henry A. (12)
Belfer, Jacob J. (11)
Belford, Ralph J. (11)
Beling, C. Abbott (7)
Bell, Horace O. (7)
Bellak, Ellis R. (6)
Belle, Louis (20)
Bellis, Horace D. (11)
Belott, August V. (7)
Belott, Louis V. (7)
Ben-Asher, Solomon (9)
Bender, Dorothea A. (20)
Bender, Louis (7)
Bender, Theodore (16)
Bengelsdorf, Aron (7)
Benjamin, Harold C. (9)
Benjamin, Joseph F. (16)
Bensley, Maynard G. (20)
Bentley, David F., Jr. (4)
Benz, Francis J. (14)
Benz, George, L. (7)
Berardinelli, Carmine G. (7)
Berenson, Samuel J. (20)
Beres, Albert J. (2)
Berg, Samuel (7)
Bergen, Marshall (9)
Berger, Harold R. (20)
Berger, William A. (7)
Bergman, Meyer W. (7)
Bergmann, Ewald H. (19)
Bergmeyer, Josef T. (9)
Berk, M. David (16)
Berke, Raynold N. (2)
Berkhout, Peter G. (16)
Berkow, Abraham (2)
Berkow, Samuel G. (12)
Berkowitz, Benjamin (6)
Berlin, Joseph I. (9)
Berlin, Morris R. (7)
Berman, H. Robert (7)
Berman, Jacob J. (11)
Berman, Leonard M. (20)
Berman, Sol (20)
Bernell, Stanley P. (4)
Berney, Irving (7)
Berney, Ruth V. (7)
Bernhard, William G. (7)
Bernheisel, Louis E. (5)
Bernson, Samuel T. (16)
Bernstein, Arthur (7)
Bernstein, Bertram (11)
Bernstein, Julius (7)
Berry, C. Hartley (20)
Berry, Leonard M. (11)
Bertha, Nicholas A. (14)
Bertland, Alexander D. (21)
Beshlian, Hagop K. (16)
Besson, Franklin J. (7)
Betancourt, Raul R. (4)
Betts, R. Winfield (3)
Bew, Richard C. (1)
Beyer, Othmar J. (7)
Bianchi, Angelo R. (7)
Bianco, John J. (4)
Biber, David (20)
Bibighaus, Warren Y. (4)
Biczak, Arkad K. (16)
Bieber, Harold B. (9)
Bigliani, Urban R. (9)
Binder, Charles I. (7)
Binder, Joseph (13)
Bird, Frank L. (14)
Bird, Ivan F. (11)
Birdsall, Clarence A. (7)
Birrell, Russell G. (20)
Bissett, John V. (7)
Biunno, Anthony J. (7)
Black, Maskell B. (8)
Black, Max S. (20)
Blackburne, George (7)
Blackwell, Enoch (11)
Blair, Thomas D. (20)
Blaisdell, C. Byron (13)
Blake, Albert J. (16)
Blake, Dexter B. (14)
Blakey, Abram P. (9)
Blanchard, Charles L. (14)
Blasi, Benjamin (7)
Blasi, Clifford (7)
Blatt, David (20)
Blaugrund, Samuel (11)
Blauvelt-Wells, Grace B. (2)
Bleasby, Charles B. (2)
Bleiberg, Jacob (7)
Blenkle, Victor A. (2)
Bloch, Harry (20)
Block, Charles (7)
Block, Marcus T. (7)
Block, Max (7)
Block, Milton (7)
Bloom, G. Homer (21)
Blum, Milton (9)
Blumberg, A. William (15)
Blumberg, Jack (20)
Blythe, Rowland P. (20)
Bobadilla, Juan E. B. (14)
Bocchini, Joseph A. (7)
Boehm, Herbert (20)
Bohl, Louis J. (16)
Bokor, Emery (7)
Boland, Lucy E. (9)
Bolanowski, Kasimier J. (20)
Bolten, Bernard (7)
Bomar, Wirrion L. (20)
Bonanno, Peter J. (2)
Bongiorno, Henry D. (16)
Bonnet, W. Laurence (11)
Bono, Joseph J. (2)
Bonomo, Michael J. (7)
Bookrajian, Edward N. (9)
Bookstaver, Barnet S. (2)
Booth, George R. (8)
Booth, Herbert W. (13)
Booth, Walter S. (20)
Booth, William K. (14)
Boqulst, Walter A. (21)
Borchek, Arthur R. (9)

Borkow, Philip (14)
Bornstein, David (16)
Bornstein, Paul K. (13)
Borow, Henry (18)
Borow, Louis S. (18)
Borrella, Dominic D. (11)
Borrone, Milton G. (9)
Borrus, Joseph C. (7)
Borshaw, Hyman (9)
Borsher, Irving P. (7)
Bortone, Frank (9)
Bosch, Taeke (2)
Boselli, Emile H. (9)
Bossard, Harry B. (21)
Bossone, Joseph E. (13)
Bostwick, Delazon S. (6)
Bostwick, Wallace R. (21)
Botbyl, Burt W. (16)
Botti, John A. (9)
Boudwin, Norman K. (3)
Bourns, Edward G. (20)
Bove, Joseph (7)
Bowen, Robert N. (4)
Bowers, F. Clyde (14)
Bowersox, Clarence A. (8)
Bowles, Harry H. (20)
Bowman, Ned O. (12)
Boyd, John B. (13)
Boyd, Robert P. (20)
Boyd, William B., Jr. (19)
Boyer, Charles G. (10)
Boyer, Paul K. (20)
Boyers, Sidney S. (9)
Boyes, James G. (20)
Boylan, Lawrence B. (16)
Boylan, Matthew E. (9)
Boyle, Francis L. (9)
Boysen, Otto T. (4)
Bozzi, Robert (7)
Brackett, Elizabeth R. (7)
Bradasch, George A. (9)
Bradford, Stella S. (7)
Bradley, Muriel (7)
Bradley, Robert A. (1)
Brady, Frank J. (7)
Brady, Raymond J. (7)
Brady, Thomas S. (9)
Braitman, Max (9)
Brakeley, Elizabeth (7)
Bramble, Halsey S. (17)
Brams, William M. (7)
Brancato, Peter (16)
Brancone, Alphonse M. (16)
Brandchaft, Bernard (7)
Brandman, Otto (7)
Branin, Howard S. (6)
Branon, Mark E. (2)
Brasefield, Edgar N. (21)
Brauer, Charles (9)
Brauer, Selig L. (9)
Braun, Gustav A. (7)
Braun, Joseph C. (2)
Braun, William (4)
Braunstein, Sigmund C. (9)
Braunstein, William P. (9)
Braunwarth, Robert J. (20)
Bray, William E. (3)
Bregman, Alexander (2)
Bregman, Milton (13)
Breitstadt, Charles A. (7)
Breme, Julius C. (4)
Bremer, Kenneth M. (7)
Brennan, Alfred T. V., Jr. (2)
Brennan, Charles L. S. (4)
Brennan, John P. (4)
Brennan, Ralph J. (2)
Brescia, James (2)
Bresev, Morris (9)
Breslow, Alexander E. (20)
Breslow, Samuel (12)
Brethwaite, Samuel H., Jr. (20)
Breuder, Andrew B. (14)
Brewer, Catherine H. (9)
Brewer, David R., Jr. (8)
Brezinski, Edward J. (12)
Brick, George J. (9)
Briggs, Henry (7)
Brim, Anne J. S. (7)
Brindle, Harry R. (13)
Brittain, Elmore G. (18)
Brizard, Joseph L. (7)
Broadnax, Mary E. (7)
Brock, Howard F. (20)
Brodkin, Eva T. (7)
Brodkin, Henry A. (7)
Brodkin, Louis A. (7)
Brody, Morton S. (12)
Brogan, Francis B. (16)
Brokaw, Christopher A. (20)
Bromberg, Charles B. (16)
Bronner, Alfred (16)
Brooks, George M. (5)
Brooks, Sidney S. (16)
Broselow, Benjamin G. (8)
Brotman, Harry (7)
Brotman, Morton M. (7)
Brower, Francis M., III (8)
Brown, Chester R. (7)
Brown, Chester T. (12)
Brown, Edith L. (13)
Brown, Frank H., Jr. (20)
Brown, Harold W. (7)
Brown, J. Carlisle (1)
Brown, John L. (2)
Brown, Kenneth G. (13)
Brown, L. Greeley (20)
Brown, Lewis W. (7)
Brown, Marcus (4)
Brown, Robert C. (6)
Brown, Stanley L. (4)
Brown, William H. (20)
Browne, George F. (7)
Browning, William J. (4)
Brozdowski, John J. (9)
Brozyna, Mieczyslaw (2)
Bruning, Richard H. (7)
Brunkow, Charles D. (7)
Bruno, Anthony (20)
Buchanan, Ralph M. L. (21)
Buchanan, Robert W. (20)
Buckley, Jeremiah L. (7)
Buckley, Paul J. (2)
Buckley, Richard T., Jr. (3)
Buckner, Roscoe W. H. (7)
Budd, J. Reuben (16)
Buermann, August, III (7)
Buermann, Robert (15)
Buffey, Walter H. (20)
Bull, Louis M. (7)
Bull, William J. (7)
Bullen, Victor E. (16)
Bump, Samuel C. (2)
Bundens, Warner D., Jr. (8)
Bunnell, Frederick N. (15)
Burbidge, J. Raymond (11)
Burke, Leonard P. (7)
Burke, Stephen E. (7)
Burkett, J. Paul (8)
Burkett, Wendell J. (8)
Burkhead, Howard C. (13)
Burn, Victor E. (19)
Burne, John J. (7)
Burnett, Charles B. (12)
Burnett, Lawrence F. (7)
Burnham, Lyman (2)
Burns, Geoffrey C. H. (2)
Burns, Joseph R. (11)
Burns, Wilmer F. (4)
Burokus, William (2)
Burpeau, William P. (7)
Burrill, Benjamin B., Jr. (7)
Burritt, Norman W. (20)
Burroughs, Edmund W. (11)
Burstein, Frank (7)
Burstein, Leo Q. (7)
Burstein, Rachel (7)
Busansky, Samuel T. (3)
Busch, Herman (7)
Bush, Archer C. (7)
Bush, Ralph K. (4)
Busicco, Philip S. (2)
Butan, Louis (7)
Butcher, Charles (6)
Butenas, Joseph J. (20)
Butler, Samuel S. (4)
Butler, Vincent P. (9)
Butterfield, Arey A. (16)
Buvinger, Charles W. (7)
Byck, Louis (7)
Byer, M. Yale (11)
Byrne, J. Arthur (14)
Byrnes, Elizabeth W. (7)
Bythewood, Alton E., Jr. (7)

ASSOCIATE MEMBERS

Banta, Edward E. (13)
Bass, Morris (7)
Becker, Meyer (12)
Becker, Sylvia F. (7)
Beim, Norbert (16)
Bellucci, Frank D. (7)
Bensel, Arlington, Jr. (7)
Berkow, Bori (12)
Berkowitz, Eva R. (11)
Bernstein, Israel (7)
Bew, David F. (1)
Bielski, Johannes F. (12)
Bombardieri, Anthony (7)
Boogdanian, Victor H. (12)
Born, Joseph (16)
Bosch, Donald T. (7)
Brawer, Jerome (16)
Bristol, Frank E., II (12)
Bromberg, Jules H. (7)
Brown, Francis S. (1)
Brown, Milton B. (12)
Bruzza, George (13)
Budnicki, Xavier B. (12)
Buford, Charles C., Jr. (11)
Buklad, Henry P. (16)
Burch, Reynold E. (7)
Burchell, Frank H. (16)
Burell, Vincent A. (11)
Burroughs, Charles W. (11)

C

ACTIVE MEMBERS

Cacciarelli, Robert A. (7)
Cagan, Maclyn (7)
Caggiano, Anthony P. (7)
Cahill, Laurence A. (7)
Calabrese, Dino (2)
Calasibetta, Charles J. (7)
Caldwell, Donald M. (7)
Caldwell, George W. (2)
Caleca, Jack J. (19)
Callahan, Edward J. (20)
Calligaro, Egildo A. (16)
Calvert, William C. (7)
Calvin, Charles H. (12)
Camche, Leo J. (7)
Cameron, Albert (18)
Cameron, Arthur E. (7)
Cameron, C. Paul (5)
Cameron, Edwin A. (7)
Campana, Vincent R. (9)
Campbell, Charles P. (2)
Campbell, Everette L. (7)
Campbell, James M. (2)
Campbell, William (7)
Campo, A. Guy (8)
Campo, Salvatore T. (8)
Candio, Vincent P. (2)
Cangemi, Vito F. (9)
Cannata, Benjamin (12)
Cannis, John P. (20)
Cannon, Edward A. (9)
Canright, Cyril M. (20)
Cantalupo, Emidio (7)
Cantelmo, Alphonse L. (7)
Cantini, Raphael S. (20)
Capell, Harry H. (16)
Capio, Mario D. (16)
Cappiello, William (7)
Caprio, Orlando G. (7)
Captanian, Aram A. (13)
Caputo, Anthony R. (7)
Carabelli, A. Albert (11)
Carbone, Francesco N. (7)
Carbone, Ralph (2)
Card, Charles F. (20)
Cardinale, Pasquale F. (20)
Cardwell, Edgar P. (7)
Carey, David S. (13)
Caridi, Salvatore (9)
Carlander, Oswald R. (4)
Carleton, Charles K. (14)
Carlin, Edward J. M. (20)
Carlisle, J. Mallory (20)
Carlisle, John H. (16)
Carlisle, Paul E. (7)
Carll, Jesse W. (6)
Carlough, David J. (16)
Carlucci, Angelo M. (18)
Carman, Fletcher F. (7)
Carmona, L. Roberto (15)
Carney, John W. (9)
Carpenter, Cedric C. (20)
Carr, Josephus C. (7)
Carr, Mary B. (9)
Carrigan, Francis P. (7)
Carrol, Wilfred (7)
Carroll, Bruce J. (20)
Carroll, C. Walter (11)
Carroll, Thomas R. (2)
Carroll, William V. (11)
Carsley, Sidney H. (20)
Carter, Joseph F. S. (13)
Cartisser, Joseph J. (19)
Cartnick, Louis C. (2)
Carusi, Leonardo G. (16)
Caruso, Paul F. (2)
Casale, John B. (7)
Casciano, Adolph D. (9)
Case, Clarence E., Jr. (18)
Casey, Robert B. (20)
Casilli, Arturo R. (20)
Casselman, Arthur J. (4)
Cassini, Henry C. (7)
Cassio, William L. (7)
Castaldo, Neil (20)
Castellano, Martin G. (7)
Catania, Joseph P. (2)
Catanzaro, Francesco (16)
Catapano, John (2)
Catlaw, J. Kenneth (9)
Catlett, George F. (19)
Cavalli, Ralph D. (4)
Cebula, Jerome M. (9)
Cella, Charles F. (11)
Cerone, Daniel M. (7)
Cerreto, Frank R. (7)
Cestone, Canio (7)
Cetrulo, Gerald I. (7)
Chaiken, Louis H. (20)
Chalfant, William P. (8)
Chamberlain, Richard R. (7)
Champlin, Paul M. (7)
Chandler, Swithin, Jr. (11)
Chapman, Ellis J. (9)
Chapman, Otis P. (20)
Chapman, Walter I. (9)
Chapnick, Maurice M. (16)
Charleroy, Durant K. (11)
Charlton, C. Coulter (1)
Charney, William (16)
Chase, Anthony V. (18)
Chase, Kalman, Jr. (2)
Chayes, Sydney (9)
Cherashore, Harry N. (7)
Chernus, Jack (7)
Cherry, Homer H. (16)
Cheskin, Louis J. (7)
Chesler, Maurice (17)
Chesley, Norman K. (8)
Chesner, William A. (11)
Chester, Saul W. (16)
Chianese, C. Chester (11)
Chiaramida, Joseph (7)
Chieffo, Henry (9)
Chiger, Alexander S. (7)
Childers, Robert J. (20)
Chilton, Forrest S. (16)
Chimacoff, Hyman (7)
Chizik, John J. (9)
Chmelnik, Abraham G. (7)
Chodosh, Maurice A. (20)
Chrisman, Irving (16)
Christian, Henry A. (9)
Christoph, Francis T. (7)
Chudzik, Edward W. (16)
Church, Charles F. (12)
Churg, Jacob (16)
Ciampa, Ralph P. E. (13)
Ciccone, Anthony C. (16)
Ciccone, Edwin L. (7)
Cichon, Elmer J. (16)
Cicione, Edward (3)
Cieri, Daniel S. (9)
Cincotti, Victor (7)
Citrino, Robert J. (7)
Clarie, D'Arcy C. (2)
Clark, Alice L. (11)
Clark, Ernest W. (4)
Clark, Frank G. (10)
Clark, John C. (13)
Clark, Margaret A. (2)
Clark, Morris B. (4)
Clark, Orlo H. (16)
Clark, S. Worth (1)
Clarke, Francis M. (12)
Clarken, Joseph A. (7)
Cleary, Joseph P. (1)
Clement, Baxter L. (7)
Clement, John B. (11)
Close, Byron H. (16)
Cloud, Albert W. (2)
Clunan, Ambrose P. (11)
Coburn, J. Wesley (7)
Coe, Edward M. (20)
Coffin, Henry F. (7)
Cogan, Henry (16)
Cohan, Charles C. (11)
Cohan, Joseph (11)
Cohen, Harry X. (20)
Cohen, Herman (9)
Cohen, Herman (11)
Cohen, Herman N. (9)
Cohen, I. Elvin (7)
Cohen, Julian (16)
Cohen, Louis (16)
Cohen, M. Marvin (16)
Cohen, Maurice (7)
Cohen, Maurice B. (5)
Cohen, Oscar H. (14)
Cohen, Paul (4)
Cohen, Samuel (9)
Cohen, Samuel A. (9)
Cohen, Sidney L. (7)
Cohen, Sidney P. (7)
Cohen, William (11)
Cohn, George M. (7)
Cohn, Hermann (7)
Cohn, Isidor (16)
Cohn, Royal M. (7)
Colavita, James J. (11)
Colby, Maxwell X. (13)
Cole, L. Frank (16)
Cole, Nathaniel B. (12)
Cole, Walter H., Jr. (20)
Coleman, Austin H. (10)
Coleman, Joseph G. (19)
Coleman, Russell M. (7)
Collier, Martin H. (4)
Collins, John F. (1)
Collins, Laurence M. (14)
Collins, Louis K. (8)
Colmer, M. Jonas (7)
Colsh, LeRoy L. (7)
Colton, Ethan T., Jr. (7)
Comando, Harry N. (7)
Comeau, George W. (14)
Comfort, John B. (11)
Commini, Frank F. (11)
Comora, Herman C. (9)
Comunale, Anthony R. (20)
Conlen, Richard (4)

Conlon, Philip J. (7)
Connamacher, Harold S. (7)
Connell, Emmet J. (9)
Connell, James (4)
Connell, John N. (9)
Connolly, John J. (7)
Connolly, Joseph A. (20)
Connolly, Joseph P. (16)
Connolly, Richard N. (7)
Connolly, Thomas W. (9)
Connor, Clarence A. (2)
Conover, Elizabeth (20)
Conserva, Peter V. (16)
Constad, Arnold N. (20)
Conte, Andrew N. (11)
Conti, Horace (7)
Conti, Michael (9)
Conty, Anthony J. (9)
Conway, James V. (20)
Cook, Caroline S. (18)
Cook, Dora G. (14)
Cook, Homer E. (18)
Cook, Hugh F. (7)
Cooley, Justus H., II (18)
Cooper, David P. (7)
Cooper, Howard M. (2)
Cooper, Irving J. (12)
Cooper, Jehu P. (13)
Cooper, Jules (5)
Cooper, Ray C. (21)
Cooper, Robert A. (4)
Cooperman, Eli L. (12)
Cooperman, William (7)
Copleman, Benjamin (12)
Copleman, Hyman B. (12)
Coplin, George J. (20)
Coppoletta, Joseph M. (2)
Corbusier, Harold D. (20)
Corio, George A. (11)
Corless, Joseph F. (9)
Corn, David (2)
Cornish, Charles H. (7)
Cornwell, Robert A. (5)
Corrigan, Patrick H. (11)
Corson, Filbert R. (1)
Corson, Kenneth E. (6)
Cortese, Alvin E. (16)
Cortese, Joseph T. (7)
Corwin, Emanuel M. (14)
Cosgrove, Robert A. (9)
Cosgrove, Samuel A. (9)
Costa, George J. (9)
Costabile, Vincent (2)
Costello, William F. (14)
Cosulich, Livio (2)
Cott, A. Allan (7)
Cotton, Henry A., Jr. (11)
Cotton, Norman T. (16)
Cottone, R. John (11)
Cottrell, Judson G. (12)
Coughlan, Ella A. (7)
Coughlin, Frank J. (7)
Coughlin, John P. (9)
Coughlin, Joseph J. (2)
Coultas, Aldo B. (14)
Covino, Louis L. (7)
Cowlbeck, H. Donald (11)
Cox, Harold C. (11)
Cox, J. Robert (17)
Cox, John C. (7)
Cox, William T. R. (20)
Cox, William W. (7)
Coxson, Harold P. (4)
Crabtree, Loren H. (20)
Cracco, Frederick A. (9)
Craig, Henry A. (18)
Crandall, John K. (2)
Crane, Bernard (1)
Crane, Charles G. (7)
Crane, Norman T. (20)
Crapanzano, Domenico (7)
Crater, Kenneth E. (7)
Crawford, Georgina U. (7)
Crecca, Anthony D. (7)
Crecca, Joseph V. (7)
Crecca, William D. (7)
Cregar, John S. (7)
Cremens, John F. (16)
Crescente, Fred J. (16)
Cricco, Carl F. (9)
Crisonino, Philip D. (9)
Crist, Walter A. (4)
Cronin, Francis J. (20)
Crooks, William J., III (10)
Cropsey, Charles D. (2)
Crossfield, Henry C. (7)
Crounse, David R. (16)
Crowe, Aldrich C. (5)
Crowley, Joseph W. (4)
Cryder, Millard C. (5)
Crystell, Edward H. (7)
Ctibor, Vladimir F. (10)
Cufari, Carmine J. (9)
Culver, Perry (7)
Cummins, Ella F. (14)
Cunningham, Charles, Jr. (6)
Cunningham, Joel B. (4)
Cuono, Joseph D. (7)
Cupaiuoli, Richard A. (7)
Curry, Marcus A. (14)
Curtis, A. Maurice (16)
Curtis, Donald A. (2)
Curtis, Elbert A. (7)
Curtis, Howard C. (3)
Cutler, Milton (1)
Cziraky, Anton (9)

ASSOCIATE MEMBERS

Canaan, Robert (16)
Carnrick, Millard, Jr. (7)
Catanzaro, Vincent J. (2)
Christian, Elizabeth I. (11)
Chromow, Bernard (7)
Ciccone, Roy (16)
Cockburn, Wilfred P. (7)
Collis, Abraham S. (13)
Comando, Edward N. (7)
Cone, Thomas E., Jr. (11)
Conner, Herbert A. (7)
Cowen, Mortimer I. (12)
Crane, Warren E. (11)

D

ACTIVE MEMBERS

D'Acierno, Pellegrino A. (9)
D'Addario, Anthony R. (7)
D'Agostin, Henry (2)
D'Agostini, Alfred J. (7)
D'Agostini, Robert J. (7)
Dailey, Edward S. (7)
Dailey, Jeremiah (14)
Dalberg, Walter (20)
D'Alessandro, Arthur J. (7)
Dallam, Lloyd A. (20)
Dallio, Salvatore V. (2)
Dalton, S. Eugene (1)
Daly, Edmund J. (9)
Daly, John F. (2)
D'Amato, Charles R. (2)
D'Ambola, Philip R. (7)
D'Amico, Thomas V. (7)
Dana, Edward (2)
Dandois, George F. (5)
Dane, Charles (7)
Dane, John (7)
D'Angelo, Joseph C. (7)
Danielson, John J. (9)
Dann, Frederick J. (7)
Dante, Pasquale (7)
Dantzig, Henry (10)
Danzis, Louis (7)
Danzis, Maximillian (7)
Darby, C. Eugene (5)
Darby, I. Kermit (7)
Darden, Walter T. (7)
Darlington, Charles G. (20)
Darlington, Emlen P. (3)
Davenport, Irwin P. (11)
Daversa, Benjamin (13)
Davidson, E. Norwell (20)
Davidson, Eric W. (7)
Davidson, Harold S. (1)
Davidson, Henry A. (10)
Davidson, Maurice M. (7)
Davies, George A. (6)
Davis, A. Hobson (16)
Davis, Albert B. (4)
Davis, E. Vernon (3)
Davis, F. Cleveland (20)
Davis, Harold (2)
Davis, Harold L. (11)
Davis, Jacob M. (3)
Davis, John E., Jr. (11)
Davis, Louis (7)
Davis, Stanton H. (20)
Davis, Thomas C. (7)
Davison, C. Spencer (17)

Davison, Royden W. (11)
Davison, Wilbur S. (17)
Dawson, Harry (16)
Day, Hayward F. (18)
Day, Samuel T. (6)
Day, Willis B. (20)
Dayton, Spencer T. (2)
Dean, Guy K., Jr. (11)
Dear, Abraham L. (7)
DeBell, Peter J. (16)
DeBiaso, Cornelius V. (2)
DeCecio, Thomas (2)
DeCesare, Ferdinand J. (20)
Decker, Charles T. (20)
Decker, Frederick H. (10)
Decker, Henry B. (4)
Dedick, Andrew P., Jr. (13)
Deehl, Seymour R. (20)
DeFelice, Mario T. (14)
DeFilippis, Ralph L. (7)
DeFronzo, Morando (7)
DeFuccio, Charles P. (9)
DeFusco, G. Thomas (9)
Degenhardt, Ira H. (12)
DeGerome, James H. (7)
DeGrace, Francis H. (16)
deHellebranth, Roland T. (1)
Deibert, Irvin E. (4)
Deich, Samuel R. (16)
Deichman, Charles H. (14)
Dein, Harry (1)
Deitmaring, Francis A. (9)
Deitz, Joseph R. (11)
Delafrange, Kenneth M. (2)
Delario, Anthony J. (16)
Delatush, George A. (7)
Del Baglivo, Mario (9)
Delcau, Jules (13)
Del Deo, Nicholas V. (7)
Del Duca, Vincent P. (4)
DeLeonardis, James V. (7)
Del Guercio, Olindo (7)
DeLia, Emilio (7)
D'Elia, William J. (13)
Della Fera, Lucien F. (7)
Della Penna, Samuel J. (16)
Della Ragione, Mario (7)
Del Mauro, Alphonse (16)
Del Negro, Albert E. (7)
DeLorenzo, Francis (7)
DeMarco, Silverino V. (9)
Demaree, Richard H. (13)
Demarest, Gerald B. (20)
DeMattia, Michael (16)
DeMichele, Roland V. (7)
Dempsey, J. Harvey (4)
Demy, Nicholas G. (20)
Denbo, Elic A. (4)
Denelsbeck, J. Otis (11)
Denes, Oscar (7)
Dengler, Henry P. (20)
Dengrove, Edward (13)
Denison, Ward C. (16)
Dennison, Alfred D., Jr. (7)
DePalma, Anthony F. (7)
DePhillips, Benedict R. (7)
DePietro, Vincent P. (9)
dePons, Sarah C. (13)
DeRosa, Armand (16)
DeRosa, Louis (9)
Dershewitz, Irving (9)
DeSantis, Orazio J. (6)
DeSanto, Anthony M. (2)
DeSevo, Gerard E. (9)
DeSimone, Louis E. (13)
Desmet, Victor F. (16)
Detrano, Salvatore J. (9)
DeTroia, Frederick C. (7)
Deuell, William D. (2)
Deutel, Oscar R. (7)
Deutsch, Nathan S. (20)
DeVincentis, Henry (7)
DeVincenzo, F. Richard (9)
DeVita, Anthony J. (13)
Devlin, Arthur D. (7)
Devlin, Hugh J. (7)
deVries, John K. (7)
Dexter, Harriet E. T. (9)
DeYoe, Leon E. (16)
Dezer, Charles N., Jr. (2)
Diamond, David I. (13)
Diamond, J. George (20)
Dickensheets, James G. (4)
Dicker, Ralph L. (7)
Dickson, John D. (2)
Dickson, T. Bruce (3)
Diefendorf, Herbert W. (20)
Dieffenbach, Richard H. (7)
Dieker, Howard E. (12)
Diener, Samuel (7)
Dierwechter, Reuben (1)
DiFino, Felix J. (7)
DiGiacomo, Harry E. (7)
DiGiacomo, William H. (7)
DiGioia, John (9)
DiIelsi, Anthony J. (4)
DiLeo, Victor (7)
Dilger, Frederick G. (2)
DiMarino, Anthony J. (8)
Dimitrow, Helen (13)
D'Imperio, Francesco (4)
Dimun, John T. (11)
Dinge, Ferdinand C. (7)
Dingman, Norman M. (16)
DiNicolantonio, Vincent J. (1)
DiNorcia, Joseph (7)
Dintenfass, Arthur (1)
Dirdack, Morris (14)
Diskan, Samuel M. (1)
Dmytriw, Stephen (7)
Dobson, Clarence D. (20)
Dochtermann, Warren P. (14)
Dodd, William E. (15)
Dodge, James T. (11)
Doggett, E. Hugh (20)
Doherty, William (20)
Doktor, David (16)
Dolsky, Irving (20)
Dolan, Gerald J. (2)
Donchi, Sol M. (7)
Donnelly, John H. (7)
Donnelly, Joseph E. (16)
Donnelly, Joseph P. (9)
Donohoe, Lucius F. (9)
Donohue, Daniel J. (9)
Donovan, Joseph (14)
Doody, William M. (9)
Doran, Ralph J. (9)
Doran, William G. (9)
Doranz, Harold K. (11)
Dorr, Henry B. (13)
Dougherty, Daniel D. (9)
Douglass, William C. (18)
Dowds, Samuel C. (7)
Downing, Perley E. (12)
Downs, Louis S. (12)
Doyle, George F. (2)
Drake, Daniel E. (16)
Drake, Leo B. (19)
Drake, Paul F. (21)
Dranow, Paul (7)
Drapkin, Berta (7)
Dredge, Thomas J. (14)
Dren, George W. (16)
Dresel, Irmgard (18)
Dreskin, Jacob L. (7)
Drewniany, Bernardine (7)
Drews, Francis F., Jr. (2)
Drezner, Henry L. (11)
Driggs, Marshall F. (2)
Driscoll, Charles D. (4)
Driscoll, Raymond S. (9)
Drossner, Jacob L. (4)
DuBois, Morris G. (7)
duBusc, L. C. Victor (20)
Dudley, Henry G. (20)
Duffy, Edward P., Jr. (7)
Duisberg, Richard E. H. (13)
Dukes, Howard R. (9)
Dulany, Theodore L. (7)
Dulin, Everett V. (7)
Duncan, Owsley B. (16)
Dunham, Malcolm M. (12)
Dunn, H. Irving (20)
Dunn, John S. (17)
Dunn, Theodore B. (7)
Dupuy, Jean G. (20)
Durchlag, E. Nelson (7)
Durham, Robert B. (1)
Durham, Royal E. (1)
Durrah, Fred F. (20)
Duschock, Edward F. (12)
Duvall, Albert I. (13)
Dwork, Harold K. (7)
Dwoyer, Leon C. (20)
Dwyer, Henry E. (16)
Dwyer, William A. (16)
Dyer, Edward H. (1)

ASSOCIATE MEMBERS

D'Agati, Vincent (2)
Davis, John (7)
DeDominicis, Frank A. (16)
Dirr, John P. (16)
Douglass, Frederick W. (7)
Drucker, Victor (2)
Duffy, William J. (7)

E

ACTIVE MEMBERS

Eames, William N. (11)
Earp, Ruth (14)
Eason, Samuel W. (20)
Ebenfeld, Samuel W. (7)
Ebner, Paul G. (4)
Echikson, Joseph I. (7)
Eck, Daniel B. (7)
Eckert, Walter L. (1)
Eckhardt, Janet L. (7)
Eckhardt, Ralph A. (14)
Eckstein, David (11)
Eddy, Lester R. (19)
Edelberg, Sidney S. (18)
Edelen, James J. (7)
Edelson, Edmond (7)
Edelson, Samuel (13)
Edelstein, Isidore (9)
Edgar, Malcolm S. (20)
Edgerly, Sherburn E. (2)
Edlkraut, Edward C. (16)
Edson, James (16)
Edwards, J. Bennett (2)
Edwards, Lena F. (9)
Edwards, Walter R. (11)
Ehrenfeld, Edward (16)
Ehrenfeld, Irving (16)
Ehrlich, Edward (7)
Ehrlich, Max (20)
Ehrlich, William E. (7)
Ehrlich-Morrow, Laura E. (2)
Eichler, Bernard B. (7)
Ein, William B. (7)
Einhorn, Samuel E. (7)
Eisemann, Jerome S. (16)
Eisenberg, David S. (7)
Eisenhower, J. S. D. (5)
Eisenstodt, Lester W. (7)
Ekings, Frank P. (16)
Elias, Elmer J. (11)
Ellenbogen, Leonard S. (1)
Elliott, Frazier J. (1)
Ellis, Alexander (4)
Ellis, Arthur J. (7)
Ellis, Ralph W. (11)
Ellmers, Basil J. (2)
Elsasser, Theodore H. (9)
Elwell, Alfred M., Jr. (3)
Elwood, Benjamin J. (9)
Ely, Lancelot (18)
Emerson, Linn (7)
Emmer, S. Wolfe (7)
Emory, George B., Jr. (14)
Engelhart, Ferdinand K. (11)
Englander, Charles (7)
English, Harrison F., III (11)
English, John T. (7)
English, Samuel B. (10)
Enright, James G. (9)
Epstein, Harry B. (7)
Epstein, William M. (7)
Erber, Leonard B. (1)
Erdman, George L. (7)
Erler, Robert E. (7)
Ernest, Richard B. (11)
Ernst, Philip A. (1)
Ervin, Millard B. (7)
Esposito, Amedeo C. (14)
Esposito, Anthony L. (16)
Esposito, Antonio L. (1)
Essertier, Edward P. (2)
Essertier, Harland C. (2)
Esty, Geoffrey W. (20)
Etheridge, Charles H. (7)
Ettinger, Samuel (9)
Eulner, Elmer H. (12)
Evans, Charles H. (7)
Evans, David P. (7)
Evans, Edgar E. (17)
Evans, Edgar J. (14)
Evans, J. Lawrence (9)
Evans, J. Lawrence, Jr. (2)
Ewens, Arthur E. (1)
Ewing, Harvey M. (7)
Ewing, Leslie H. (4)
Eynon, Harold K. (4)
Eynon, James R. (4)

ASSOCIATE MEMBERS

Edwards, Sydney K. (7)
Einhorn, Harvey (7)
Erskine, Frederick A. (1)
Evans, John R., Jr. (7)

F

ACTIVE MEMBERS

Faber, Edward (9)
Fabian, Paul L. (11)
Fabriele, John B. (9)
Facciolo, Frank (9)
Fadden, Francis J., Jr. (2)
Fader, Ferdinand (7)
Fager, Rudolph O. (7)
Fahrenbruch, Frederick D. (3)
Failing, Brayton E. (7)
Failmezger, Theodore R. (14)
Faison, John B. (9)
Falcone, Albert M. (20)
Falcone, Nicholas A. (18)
Falconer-Slater, Katherine (20)
Falkinburg, Le Roy W. (15)
Falvello, Nicholas A. (14)
Fanburg, Sol J. (7)
Fanelli, Antonio (12)
Farb, Harry H. (7)
Farkas, Gustav (16)
Farkas, Morris (7)
Farmer, Walter D. (11)
Farr, Walter J. (2)
Farrell, Edgar A. H. (4)
Fasano, Giovanni (7)
Fath, Marcus A. (5)
Fattel, Henry C. (9)
Faulkingham, Ralph J. (12)
Fauquier, Leonard B. (9)
Faux, Frederick J. (8)
Fava, Philip V. (7)
Fazio, Vincent J. (13)
Featherston, Daniel F. (13)
Fechner, Fred J. (2)
Fechner, Herta (2)
Fechner, Julius (7)
Federer, John J. (9)
Feher, Ladislas A. M. (12)
Feln, Bernard (7)
Feinberg, Harry (9)
Felnberg, Harry D. (13)
Feinsod, Samuel N. (7)
Feinstein, Louis (1)
Felder, Samuel (10)
Feldman, Frank H. (7)
Feldman, Morris (9)
Feleppa, Edward E. (20)
Feliciano, Vincent (16)
Felitti, Vincent J. (9)
Feller, William (9)
Feman, J. George (13)
Fendrick, Edward (7)
Fenimore, Edward D. (9)
Fenster, Morton N. (16)
Fenton, Tennant E. (13)
Fenwick, John R. (16)
Ferenchak, Ralph (20)
Ferguson, William E. (7)
Fermaglich, Harry B. (2)
Fern, Samuel S. (7)
Ferrante, Joseph (2)
Ferrari, Andrew F. (2)
Ferrari, Salvatore (16)
Ferrary, Paul B. (16)
Ferriss, Ruth B. (14)
Fessler, A. James (11)
Fessman, John W. (4)
Feuer, Joseph A. (7)
Fialk, Harry (9)
Ficke, Sylvia A. (9)
Ficker, Robert F. (16)
Fiedler, Michael J. (20)
Field, Frank L. (18)
Fielding, William M. (16)
Fiering, Abraham M. (16)
Fietti, Vincent G. (2)
Fifer, William T. (9)
Figliolino, Francis (20)
Figurelli, Francis A. (9)
Filkins, Cedric E. (4)
Finby, Nathaniel (14)

Fine, Hyman P. (12)
Fine, Irvin J. (12)
Fine, Sydney G. (11)
Fineberg, Jacob C. (9)
Finegan, Paul J. (11)
Finger, Frederick A. (9)
Fink, A. Elston (7)
Fink, Irving E. (7)
Fink, Stanley J. (20)
Finke, Charles H. (9)
Finke, Charles H., Jr. (9)
Finke, George W. (2)
Finke, John H. D. (2)
Finkel, Joshua (7)
Finkelstein, Abe S. (7)
Finkelstein, Max (9)
Finkle, Lester J. (11)
Finkler, Rita S. (7)
Finn, Frederick A. (9)
Finn, Henry R. W. (9)
Finnegan, William R. (12)
Finnerty, Urban R. (7)
Fiorello, Joseph R. (11)
Fischbach, Adolph D. (3)
Fischbein, Martin M. (7)
Fischer, David D. (7)
Fischer, Edward J. (7)
Fischer, Leo E. (9)
Fischer, Louise (7)
Fischman, Harold H. (7)
Fischman, Mervin (7)
Fishbein, Elliot (16)
Fisher, James A. (13)
Fisher, Samuel (16)
Fisher, Stella C. (4)
Fishkoff, Alexander H. (12)
Fisler, Charles F. (8)
Fitch, Thomas S. P. (20)
Fithian, George W. (12)
Fitzhugh, William F. (2)
Fitzpatrick, Leo J. (2)
Flanagan, James F. (7)
Flanagan, John J. (7)
Flax, Ira I. (7)
Fleischmann, Viola G. (7)
Fleming, Charles L. (17)
Fleming, Joseph A. (7)
Flichtenfeld, Morris (9)
Flicker, David J. (7)
Fliegel, Hilda C. (9)
Fliegel, William M. (2)
Flint, Edgar T. (18)
Flitcroft, William (16)
Floody, Robert J. (7)
Flower, Morrie A. (7)
Fluck, David A. (11)
Fluck, Paul H. (10)
Flynn, Edward A. (7)
Foley, James F. (7)
Foley, James G. (14)
Folsome, Clair E. (20)
Fonda, Gerald E. (7)
Fooder, Horace M. (8)
Foote, Sherman K. (16)
Forbes, John S., Jr. (14)
Ford, Theodore R. (7)
Forer, Robert (11)
Forney, Norman N. (12)
Forney, Norman N., Jr. (12)
Fort, William B. (20)
Fortay, Steven O. (16)
Forte, Daniel L. (7)
Forte, Frank S. (7)
Fortunato, Joseph F. (7)
Fortunato, Samuel J. (7)
Fost, William H. (7)
Foster, Frank L. (20)
Foster, Herbert W. (7)
Fowler, Richard M., Jr. (1)
Fowler, Royale H. (7)
Fox, William W. (1)
Frame, Dorothy L. (7)
Francy, Donald G. (7)
Frank, Geza M. (7)
Frank, Herman I. (9)
Frank, Morris (9)
Frank, Myrtile (1)
Frank, Nathan (9)
Frank, Perry (1)
Frank, Simon C. (7)
Frankel, Theodore H. (20)
Franklin, Frank A. (7)
Franklin, I. Harold (9)
Franklin, Joseph E. (20)
Franklin, Lewis J. (20)
Frantz, Max K. (4)
Franzoni, Andrew E. (11)
Fratantuno, Michael J. (7)
Fraulo, Louis (16)
Freda, Franklin (7)
Freedman, Harold H. (13)
Freedman, Jacob S. (16)
Freeland, Frank (2)
Freeman, George C. (7)
Freeman, Joseph (9)
Freeman, Ray M. (20)
Freeman, Richard D. (7)
Freeman, William S. (12)
Freinkel, Jacob (7)
Freymann, Walter (9)
Fridrich, Harry E. (4)
Friedburg, George H. (20)
Friedenberg, Sidney (4)
Friedenthal, Bernard (12)
Friedland, Arnold J. (6)
Friedlander, Aik (20)
Friedman, Abraham I. (2)
Friedman, Edna C. (16)
Friedman, Harry (7)
Friedman, Hyman (7)
Friedman, Max (11)
Friedman, Meyer H. (11)
Friedmann, Gustav (16)
Friedmann, Leonard L. (11)
Friedrich, Adam H. (7)
Frieman, Hyman (9)
Friery, John F. (2)
Frisch, Felix (11)
Fritsch, Alfred (7)
Fritts, Lewis C. (18)
Fritz, John F., Jr. (10)
Froelich, Joseph C. (7)
Frohwein, Ida H. (20)
Fromkin, Charles (6)
Fruchtbaum, Robert P. (7)
Frutig, Harold C. (9)
Fuchs, Jacob N. (11)
Fuhrmann, Barclay S. (10)
Fuhrmann, John B. (10)
Furman, Benjamin A. (7)
Furman, Sol T. (9)
Furst, Nathan J. (7)
Furst, William (7)

ASSOCIATE MEMBERS

Fain, Irving (7)
Fernicola, Anthony R. (7)
Finkelstein, Aaron (7)
Finkelstein, Malvin (7)
Fioretti, Ralph J. (2)
Foster, H. (18)
Frederick, George F. (12)
Freund, Seelig (11)
Frosch, Frank J. (11)

G

ACTIVE MEMBERS

Gadek, Stanley A. (12)
Gadek, William V. (12)
Gadomski, Casimir F. (20)
Galgoczy, Julius (18)
Galioto, Frank M. (7)
Gallardo, Agustin (16)
Gallaway, George E. (20)
Gallo, James S. (16)
Gamba, Joseph (7)
Gambacorta, Leopoldo (7)
Gambill, Perry J. (14)
Gamon, Robert S. (4)
Gamsu, George (7)
Ganley, Arthur J. (7)
Gannon, Joseph M. (20)
Ganot, Frank I. (7)
Gantt, Margaret H. (14)
Garber, Robert S. (11)
Gardam, Joseph W. (7)
Gardner, Kenneth E. (7)
Garfinkel, Abraham (11)
Garnett, Robert (16)
Garrett, Thomas A. (2)
Garrison, Sherman (6)
Garrison, W. Sherman (6)
Gartlan, Bernard W. (15)
Garwood, Norman W. (11)
Gatti, Joseph D. (2)
Gaydos, Albert (7)
Gaylor, Earl L., Jr. (7)
Geannette, Ernest D. (7)
Geary, Daniel J. (14)
Geary, Paul (20)
Geary, Russell D. (3)
Gebele, William X., Jr. (15)
Gebirtig, Theodore (14)

Ged, Archie K. (16)
Gehl, Raymond H. (7)
Gehl, Sidney H. (7)
Geib, Margaret E. (20)
Geiger, Harold C. (16)
Geissler, Elmer E. (4)
Gelb, Jerome (7)
Gelber, Isaac (20)
Geller, Samuel (7)
Gellman, William B. (16)
Gelman, Sidney (16)
Gencher, Benjamin (7)
Gennell, Ernest (7)
Genninger, Lewis E. (21)
Gentile, Ernest R. (18)
George, Amerigo (13)
George, Melbourne E. W. (7)
Gerard, Arpad G. (12)
Gerard, Patrick D. (7)
Gerendasy, Julius (20)
Gerhardt, Paul E. (7)
Germain, Raymond J. (10)
German, George B. (4)
Gerne, Timothy A. (9)
Gerner, Harry E. (9)
Gershenfeld, David B. (7)
Gershman, Joseph G. (2)
Gessner, Gerard R. (12)
Gesswein, Carl A. (13)
Ghee, Euclid P. (9)
Giambra, Sante M. (16)
Giannasio, Joseph (9)
Gianni, Angelo R. (14)
Giardina, John S. (7)
Giardina, Vincent J. (7)
Gibb, Alice S. (20)
Gibbins, A. Leslie (7)
Gibson, Augustus (7)
Giffoniello, Arthur A. (7)
Gifford, William R. (7)
Giglio, Alphonsus S. V. (20)
Giglio, Louis A. (16)
Gilady, Raphael (2)
Gilbert, Philip D. (4)
Gilbert, Samuel M. (7)
Gilbertson, Robert L. (14)
Gillespie, John L. (7)
Gilligan, Walter W. (7)
Gilman, Leonard (7)
Gilpin, Fletcher (20)
Gindhart, Floyd D. (11)
Gindhart, John H. (11)
Ginsberg, George (9)
Ginsberg, Leon (7)
Ginsburg, Samuel (16)
Giocano, Joseph F. (20)
Giordano, Salvatore (14)
Giordano, William C. (2)
Girardo, Anthony J. (4)
Gittelman, Morton (20)
Gittelsohn, Isador (2)
Gitterman, David A. (2)
Giuffra, Frank (7)
Giuliana, Robert A. (7)
Glaser, Emanuel (20)
Glass, Benjamin E. (20)
Glass, George A. (18)
Glass, Harry L. (20)
Glass, Oscar (7)
Glass, William H. (7)
Glasser, Benjamin F. (12)
Glassner, Frank (20)
Glazebrook, Francis H. (14)
Glazier, Jesse T. (7)
Gleeson, William J. (9)
Glick, Bernard (2)
Glover, Lawrence L. (4)
Gluckman, Saul K. (7)
Glynn, S. Robert (7)
Gnassi, Angelo M. (9)
Gobel, Stanley J. (12)
Gochman, Harry M. (16)
Godfrey, Alan O. (7)
Goehring, Harrison D. (7)
Goeller, Jacob D. (7)
Goff, Frank J. (13)
Goffman, Emanuel (7)
Goldberg, Benjamin M. (11)
Goldberg, Bernard R. (7)
Goldberg, David (2)
Goldberg, Harold H. (7)
Goldberg, Harry C. (12)
Goldberg, Isidore (12)
Goldberg, Louis E. (7)
Goldberg, Samuel A. (7)
Golden, Clement H. (7)
Golden, William M. (20)
Goldenberg, Raphael R. (16)
Goldfarb, Abraham (2)
Goldfield, Harold H. (20)
Golding, Harry N. (16)
Goldmacher, Herman B. (20)
Goldman, David L. (9)
Goldman, Jerome (7)
Goldman, Leo L. (11)
Goldman, Lester M. (7)
Goldman, Samuel (4)
Goldman, Solomon (12)
Goldmann, Joseph (7)
Goldsmith, Alfred S. (9)
Goldstein, Abraham (15)
Goldstein, Benjamin (13)
Goldstein, Edward W. (16)
Goldstein, Henry Z. (7)
Goldstein, Herman H. (20)
Goldstein, Hyman I. (4)
Goldstein, Joseph D. (9)
Goldstein, Samuel (1)
Goldstein, Samuel M. (7)
Goldstone, Karl H. (9)
Golish, Harry L. (16)
Gonczy, Edward J. (20)
Good, Richard (9)
Goodman, Kenneth (7)
Goodspeed, William K. (20)
Gordon, A. Julius (7)
Gordon, Abel (16)
Gordon, Benjamin L. (1)
Gordon, Charles D. (14)
Gordon, Frank S. (21)
Gordon, Isaac L. (9)
Gordon, J. Berkeley (13)
Gordon, Maurice B. (1)
Gordon, Milton H. (4)
Gordon, Norman W. (20)
Gordon, Samuel (16)
Gordon, Sarah (2)
Gordon, William (16)
Gorenberg, Harold (9)
Gorman, Robert B. (2)
Gormley, Cyrus M. (16)
Gorog, Nicholas M. (12)
Gorson, Samuel F. (1)
Gorten, Manfred L. (7)
Gosper, Ralph W. (4)
Gottlieb, Morris (1)
Gould, John H. (16)
Gould, Werner (2)
Gove, Richard R., Jr. (15)
Goyne, James B. (11)
Graber, Irving (13)
Graddick, Lester W. (14)
Graeter, F. Albert (16)
Graham, Archibald F. (16)
Graham, Ernest E. (11)
Graham, Theodore K. (16)
Granelli, Humbert A. (9)
Granger, James R. (11)
Grant, Francis (7)
Grant, Raymond J. (14)
Grant, Russell B. (2)
Grant, William E. (20)
Grant, William F. (7)
Grasso, Anthony P. (7)
Gray, Charles M. (6)
Gray, John W. (7)
Gray, W. Burritt (18)
Greco, Lionel A. (20)
Green, David W. (17)
Green, Henry (7)
Green, Martin (1)
Green, Thomas J. (15)
Greenberg, George A. (18)
Greenberg, Jacob L. (7)
Greenberg, Max (20)
Greenberg, Philip (9)
Greenberg, Samuel (7)
Greenberg, William B. (9)
Greene, Albert D. (9)
Greene, Edwin C. (6)
Greene, Harry (9)
Greenfield, Arthur W. (2)
Greenfield, Bernard H. (7)
Greenfield, Herbert (7)
Greenfield, Leonard S. (7)
Greenfield, Sylvan J. (7)
Greenfield, William J. (2)
Greengrass, Jacob J. (16)
Greenwald, Eugene (7)
Greenwald, Theodore L. (7)
Greenwell, Albert W. (16)
Greenwood, Samuel B. (7)
Greenwood, William R. (12)
Greer, Melvin A. (7)
Gregory, Marie F. (14)
Gregory, Mildred G. (7)
Greifinger, Marcus H. (7)
Greifinger, William (7)
Grenhart, George W. (4)
Gribbin, James A. (11)
Gricco, Anthony L. (6)
Grieco, Emil H. (9)
Grier, Robert M. (1)
Griesemer, Laurence C. (20)
Griesemer, Z. Lawrence (20)
Griffey, William C. (4)
Griffin, Guy B. (7)
Griffith, Roy (7)
Grimes, Robert R. (2)
Griscom, I. Norwood (14)
Griscom, Lee E. (4)
Griswold, Merton L., Jr. (20)
Groff, Parker A. (2)
Gross, Irving (7)
Gross, Max (1)
Gross, Robert J. (2)
Grossbard, Paul (16)
Grossblatt, Philip (7)
Grossman, Morris (9)
Grossman, Rubin (9)
Grossman, Walter (12)
Gruber, William L. (7)

Grubin, Harold (7)
Grubowski, Joseph N. (9)
Gruhler, Jean A. (1)
Grundorfer, Joseph (7)
Guarraia, Joseph (16)
Guertin, Diomede (18)
Guglielmelli, Angelo D. (11)
Guidi, Guido M. (20)
Guion, Edward (1)
Gulick, James B. (7)
Gurland, Benjamin B. (9)
Gurley; Katharine A. (9)
Gurnee, Quinby D. (16)
Gurshman, Sol. (12)
Gutmann, Erwin K. (9)
Gutowski, Joseph M. (12)
Gutowski, Walter T. (7)

ASSOCIATE MEMBERS

Gambacorta, Otto (7)
Gardiner, Muriel M. (11)
Garzieri, Anthony (16)
Gear, Phillip E. (7)
German, Bernard (7)
Gerson, Stanley (16)
Gian-Grasso, Joseph A. (11)
Gianquinto, Peter (7)
Goodman, Stanley J. (7)
Gould, Louis F. (12)
Gras, Alfred E. (7)
Greco, Roger A. (7)
Grundfest, Jack (7)
Grundfest, Philip (7)
Guito, Frank (13)
Gurian, Sydney H. (7)

H

ACTIVE MEMBERS

Hackett, Daniel C. (20)
Hadley, C. Frazer (4)
Hadley, C. Frazer, Jr. (4)
Hafetz, M. Morris (11)
Haggerty, D. Leo (11)
Haggerty, Francis F. (9)
Hagovsky, Albert J. (2)
Hahn, Katherine B. (7)
Hahn, William H. (7)
Haines, Emerson S. (13)
Haines, F. B. Lane (5)
Haines, Keith E. (4)
Haines, Mabel C. S. (4)
Haines, Willits P. (5)
Halbeisen, William A. (4)
Halbstein, Bernard M. (13)
Haldeman, Robert E. (3)
Hale, Matthew J. (3)
Haley, Paul W. (7)
Hall, Perry O. (9)
Hall, Ralph A. (20)
Hall, Wayne W. (16)
Hall, Winthrop H. (20)
Haller, Olga (7)
Hallett, Frederick S. (2)
Halligan, Earl J. (9)
Hallinger, Earl S. (4)
Hallock, Wilton J. (20)
Halperin, David (9)
Halpern, Herman (2)
Halpern, Samuel (1)
Halpern, Sophia L. (9)
Halpern, William (7)
Halprin, Harry (7)
Halsey, Levi W. (7)
Hambright, Arthur M. (16)
Hamburg, Meyer M. (12)
Hamburger, Werner (1)
Hamilton, Lloyd A. (10)
Hamilton, Robert G. (7)
Hamley, John J. (20)
Hammell, Frank M. (11)
Hammett, Lee J. (4)
Hampton, George R. (14)
Hanan, James T. (7)
Hancock, Michael Q. (13)
Handelman, Sidney (7)
Handler, Harry (9)
Haney, John J. (11)
Hanrahan, James (20)
Hansen, Harold T. (7)
Hansen, Harry (20)
Hanson, Alfred S. (4)
Hanson, Carl G. (20)
Hantman, Harold (7)
Harbeson, James P., III (4)
Harden, Albert S. (7)
Harden, Albert S., Jr. (7)
Hardy, John W. (13)
Harley, Halvor L. (1)
Harley, Robison D. (1)
Harman, J. Reginald (11)
Harps, James A. (10)
Harreys, Charles W. (16)
Harrington, J. Henry (14)
Harris, Jonathan L. (7)
Harris, Leonard (7)
Harris, Maurice N. (6)
Harris, Morris (7)
Harris, Sidney (20)
Harris, William G. (8)
Harris, William O. (1)
Harryman, William K. (2)
Hart, Francis F. (13)
Harter, Louis F. (9)
Hartman, Luther M. (3)
Hartman, Winfield L., Jr. (7)
Hartmann, Edmund M. (18)
Hartwell, H. Ameroy (9)
Harvey, John W. (9)
Harvey, Robert K. (7)
Harvey, Thomas W. (7)
Harwood, Harry L. (2)
Haschec, Walter (7)
Haskin, Aaron H. (7)
Hasking, Arthur P. (9)
Hasney, Frederick A. (7)
Hatch, Harold S. (14)
Hatem, Elias J. (16)
Hathaway, George, Jr. (16)
Hauber, Eugene A. (12)
Hauck, Francis A. (5)
Hauck, Lydia R. B. (7)
Hauck, William H. (7)
Hauptman, Harry (9)
Hausman, Samuel W. (13)
Haut, Edward M. (13)
Haven, Samuel C. (14)
Hawes, Vernon L. (2)
Hawkes, E. Zeh (7)
Hawkes, Stuart Z. (7)
Hawkins, Edward R. (20)
Hawkins, W. B. (18)
Hayden, Walter G. (15)
Hayes, Gerald W. (7)
Hayman, Irving R. (16)
Hays, Roy G. (4)
Haywood, Henry (12)
Heatley, William (13)
Hebble, Howard M. (3)
Hegeman, Runkle F. (18)
Heilbrunn, Julius (9)
Heineken, Theodore S. (7)
Hekimian, Jacob H. (9)
Helff, Joseph R. (2)
Heller, Abraham R. (7)
Heller, George (2)
Heller, Nathan B. (7)
Hely, Charles J., Jr. (20)
Heminway, Norman L. (20)
Hemphill, Everett H. (4)
Hendlich, Milton G. (7)
Hendrickson, Harold W. (6)
Henle, Carye-Belle (7)
Hennig, Paul F. (7)
Henriksen, J. Bruce (15)
Henry, Frank C., Jr. (12)
Henry, George (10)
Henry, Norman (6)
Henshaw, George R. (7)
Hensle, Otto S. (2)
Herbener, Eugene G. (15)
Hermann, John H. (7)
Hernandez, Manuel (9)
Herndon, Lewis S. (7)
Herold, Harvey T. (7)
Herradora, Juan R. (9)
Herrington, Lee R. (20)
Herrman, William G. (13)
Hersh, David H. (7)
Hershey, Harry H. (9)
Hersohn, William W. (1)
Hertzberg, Irving (7)
Hess, George A. (11)
Hess, L. Elmore (1)
Hesseltine, Clair E. (12)
Hessert, Edmund C. (4)
Hewson, George F. (7)
Heyman, Arthur (7)
Heyman, Jacob (7)

Heymann, Ernest F. (13)
Hicks, Alfred M. (7)
Hiden, Joseph C. (11)
Higgins, Gerald L. (9)
Higgins, John T. (9)
Higgins, Thomas A. (9)
Higi, Joseph E. (7)
Hiler, Stuart A. (14)
Hilker, George F. (12)
Hill, Clarence T. (20)
Hill, Dean F. (19)
Hill, James O. (7)
Hill, Robert H. (7)
Hillel, Joseph (9)
Hilliard, William T. (17)
Hillman, Ernest C., Jr. (7)
Hillsman, R. Bryan (2)
Hilton, Clarence O. (7)
Hinckley, Livingston S. (7)
Hindle, F. Lawton (13)
Hipple, Percy L. (20)
Hird, Emerson F. (18)
Hirsch, Arthur (5)
Hirsch, John J. (2)
Hirsch, Lucien (20)
Hirsch, Solomon (9)
Hirsch, Theodore (7)
Hirschfield, Bernard A. (11)
Hirshorn, Arthur (4)
Hitschmann, Otto B. (7)
Hitzemann, Louis A. (2)
Hnat, Frederick (20)
Hobart, Richard T. (7)
Hoch, Samuel M. (20)
Hochheimer, Arthur (18)
Hochman, Alex (16)
Hodas, Sidney M. (13)
Hofbauer, Ernest (11)
Hofer, Clarence J. M. (12)
Hofer, William R. (4)
Hoffman, Charles A. (20)
Hoffman, Charles W. (12)
Hoffman, Florentine M. (12)
Hoffman, Harry (20)
Hoffman, Harry S. (1)
Hogan, Marshall D. (14)
Holder, Lester (7)
Holderith, Albert E. (7)
Holland, Moses H. (9)
Holland, Reuben J. (20)
Holler, Henry G. (7)
Hollingsworth, H. Hale (16)
Hollinshed, Beulah S. (4)
Hollinshed, Ralph K. (8)
Hollywood, James L. (9)
Holman, Francis W. (13)
Holmes, George J. (7)
Holmes, Grace A. (20)
Holmes, H. David (1)
Holmes, Thomas J. E. (16)
Holoman, M. Browne (1)
Holster, Stephen G. (16)
Holt, Evelyn (20)
Holt, Herman H. (16)
Holters, Otto R. (13)
Holtz, Harry M. (7)
Holtzman, Michael (20)
Hoops, Harold J. (2)
Hooton, Thomas C. (7)
Hopper, Guy R. (20)
Hopper, John B. (14)
Hopping, John S. (14)
Hopping, Richard A. (7)
Horhovitz, George I. (11)
Horland, Aaron H. (7)
Horland, Ephraim (7)
Horn, Harry (7)
Horn, Max (7)
Hornberger, J. Howard (3)
Horner, John I. (4)
Hornick, Emil E. (14)
Hornstine, Harry H. (5)
Horoschak, Anne (20)
Horowitz, Alexander S. (9)
Horowitz, Herman J. (2)
Horowitz, Leo (9)
Horowitz, Robert (9)
Horre, George W. H. (20)
Hosp, Paul H. (7)
Howard, J. Edgar (4)
Howard, James W. (7)
Howell, E. Gaylord (12)
Howell, Thomas W. (7)
Howeth, John L. (9)
Howley, Barth, Jr. (12)
Hubach, Maximilian F., Jr. (7)
Hubbard, Robert Y. (7)
Huber, William H. (7)
Huberman, John (7)
Hubert, Antonio O. (14)
Hudson, Howard S. (1)
Hughes, A. Joseph (4)
Hughes, Frank J. (4)
Hughes, Frederic J. (20)
Hughes, Harold F. (5)
Hughes, J. Vernon (16)
Hughes, James W., Jr. (1)
Hughes, Joseph F. (8)
Hughes, Lee W. (7)
Hughes, Samuel B. (5)
Hughes, Thomas E. (4)
Hulett, Albert G. (7)
Hull, Donald B. (2)
Humbert, Joseph C., Jr. (21)
Hummel, Ernest G. (4)
Hummel, Frederick W. (13)
Hummel, Lee C. (17)
Humphrey, Hubert G. (20)
Humphries, Robert E. (7)
Hunt, Melvin M. (12)
Hunt, Thomas F. (20)
Hunter, Edward R. (3)
Hunter, Floyd D. (11)
Hunter, Harold H. (8)
Hunziker, George P. (2)
Hurff, J. Wallace (7)
Hurtado, Edward (20)
Huss, Louis (9)
Husted, Gerald W. (4)
Husted, Samuel H. (18)
Hutchinson, A. Dunbar (11)
Hutchinson, George F. (11)
Hutner, Cyril I. (12)
Hutton, Frederick T. (20)
Hyde, Robert T. (7)
Hyer, Godfrey S. (18)
Hyland, Michael (7)
Hyman, Charles (1)
Hymowitz, Ben (7)

ASSOCIATE MEMBERS

Hall, Mary B. (11)
Hanfling, Seymour L. (7)
Hardin, Edmund B. (11)
Haslam, Herbert M. (11)
Herman, Isadore (16)
Hermann, John H., Jr. (7)
Hill, Arthur G. (7)
Huberman, Victor (7)

I

ACTIVE MEMBERS

Ianacone, John A. (16)
Iannone, Angelo B. (7)
Iatesta, Matthew (7)
Ill, Edmund W. (7)
Ill, Herbert M. (7)
Imbleau, Joseph E. L. (20)
Imhoff, John G. (9)
Imhoff, Robert E. (4)
Infield, Gerald L. (1)
Inge, Hutchins F. (7)
Inge, Theodore R. (7)
Introcaso, Dominick A. (9)
Iraggi, James V. (16)
Ironside, Paul A. (4)
Irwin, Francis T. (7)
Irwin, James R. (7)
Irwin, John H. (2)
Irwin, Robert C. (2)
Isaac, Benoit C. (7)
Isen, Paul J. (13)
Israel, Joseph (7)
Israeloff, Howard H. (7)
Ivey, Evelyn P. (14)
Ivins, William C. (11)
Ivory, Harry S. (15)
Izenberg, David (16)

ASSOCIATE MEMBERS

Insabella, John (7)
Insolera, John A. (16)
Ittleman, Wm. S. (12)

J

ACTIVE MEMBERS

Jablonski, John J. (4)
Jack, H. Wesley (4)
Jacks, Oscar (9)
Jackson, Charles H. (4)
Jackson, Elmer C. (21)
Jackson, George H. (7)
Jacobittl, Edmund E. (2)
Jacobs, Alan L. (20)
Jacobs, Benjamin (7)
Jacobs, William (7)
Jacobson, Benjamin D. (12)
Jacobson, J. Joseph (1)
Jacobson, Murray B. (12)
Jaeckle, Charles E. (7)
Jaffe, Benjamin (9)
Jaffe, Gorman (15)
Jaffe, Herman M. (9)
Jaffe, Hyman (16)
Jaffin, Abraham E. (9)
Jahn, Albert G. (16)
Jaksch, Maria (9)
James, Bart M. (7)
Jamison, William F. (13)
Jani, Frank F. (16)
Jaques, J. Eugenia (9)
Jarecki, Max M. (13)
Jarvis, Daniel G. (7)
Jaslow, Seymour P. (2)
Jaso, James V. (7)
Jaspan, Samuel C. (11)
Jedel, Meyer (7)
Jehl, Joseph R. (16)
Jenkins, Alvah R. (2)
Jenkins, Arthur M. (10)
Jenkins, R. Jewett (7)
Jennings, Robert E. (7)
Jensen, Grover H. (9)
Jentz, John H. (9)
Jessurun, Samuel H. (7)
Joelson, Dora (16)
Joelson, Morris S. (16)
Joffe, Philip M. (16)
Joffe, Sidney H. (16)
Johnsen, Sigurd W. (16)
Johnson, Archie W. (9)
Johnson, George F. (19)
Johnson, G. Leonard (2)
Johnson, Harold F. (20)
Johnson, Herbert F. (4)
Johnson, John F. (11)
Johnson, Robert A. (7)
Johnson, V. Earl (1)
Johnson, Winton H. (2)
Johnston, Julian F. (14)
Jonas, August (17)
Jones, Clement M. (9)
Jones, Helen E. (13)
Jones, Herbert E. (20)
Jones, J. Morgan (9)
Jones. John C. (4)
Jones, Lewis H. (20)
Jones, William F. (18)
Jonitz, Robert (7)
Jordan, Joseph C. (13)
Jordan, Walter L. (2)
Joseph, Benjamin M. (9)
Joseph, Morris (16)
Judd, Joseph, Jr. (20)
Judge, John F. (7)
Judson, G. Vernon, Jr. (4)
Just, Francis (7)
Justin, Arthur W. (9)

ASSOCIATE MEMBERS

Jasionowski, Edward (12)
Judge, Thomas V., Jr. (7)
Jurewicz, Stanley T. (16)

K

ACTIVE MEMBERS

Kachdorian, Vartan (11)
Kaderabek, Erwin J. (7)
Kahn, Leo (1)
Kahrs, Grace M. (7)
Kahrs-Dreyfors, Madeline (13)
Kaighn, Charles B. (1)
Kain, Thomas M. (4)
Kain, Thomas M., Jr. (4)
Kainer, Herbert (9)
Kakascik, Emil J. (2)
Kalb, S. William (7)
Kaletkowski, Marion F. (16)
Kallen, Arnold M. (7)
Kalter, George E. (7)
Kaman, Samuel L. (1)
Kamp, Maurice (9)
Kandra, Paul H. (20)
Kanengiser, Clifford H. (9)
Kaney, Emil M. (7)
Kaplan, Harry (11)
Kaplan, Henry L. (7)
Kaplan, Herman B. (9)
Kaplan, Isaac (2)
Kapp, Carl G. (20)
Karel, Jack R. (20)
Karnay, Francis (20)
Karshmer, Ernest E. (20)
Karshmer, Nathan (12)
Kassel, Mortimer H. (16)
Kassow, Philip B. (21)
Kastler, Franz (2)
Katz, Harry (16)
Katz, Herbert I. (16)
Katz, Jacob D. (9)
Katz, Sidney (9)
Katz, Theodore (20)
Katzin, Eugene M. (7)
Kauder, Warren G. (7)
Kauffmann, Louis J. (6)
Kaufman, Jerome G. (7)
Kavanaugh, Daniel E. (7)
Kay, Albert E. (4)
Kay, Clarence R. (18)
Kazmann, Harold A. (13)
Kearney, Edward P. J. (7)
Kearney, John F. (7)
Kearney, Paul A. (7)
Keating, Charles A. (16)
Keating, Joseph M. (16)
Keats, Sidney (7)
Keeney, Cadwell B. (20)
Keeney, James C. (9)
Kehler, James G., Jr. (11)
Keil, Sigmund S. (20)
Keim, William F., Jr. (7)
Keir, Floyd E. (2)
Keith, Theodore R. (7)
Kelemen, Nicholas M. (7)
Keller, Earl B., Jr. (4)
Keller, Michael L. (16)
Keller, Rudolph J. (9)
Kelley, Charles B. P. (2)
Kelley, Ray H. (16)
Kelly, Bernard S. (9)
Kemeny, George (20)
Kemeny, Imre (12)
Kempe, George (7)
Kennedy, A. Andrew (16)
Kennedy, Eugene T. (16)
Kennedy, George R. (4)
Kennedy, John N. (20)
Kennedy, John W. (9)
Kennedy, Paul A. (2)
Kennedy, William M. (7)
Kenney, John A. (7)
Kent, Donald F. (14)
Kent, Louis R. (20)
Keppler, Charles, Jr. (16)
Kerdasha, Richard F. (4)
Kern, E. Clarence (7)
Kern, Meyer J. (7)
Kesselman, Samuel R. (7)
Kessler, Edward I. (14)
Kessler, Henry B. (7)
Kessler, Henry H. (7)
Keyser, David (4)
Keyssar, Alexander (7)
Kidd, Ruth W. (20)
Kiely, Eugene M. (9)
Kiessling, Charles E. (7)
Kiley, John E. (7)
Kilts, Winfield S. (2)
Kim. Gay B. (16)
Kimche, Irwin (7)
Kimler, William D. (4)
Kimmel, Charles (7)

Kimmel, M. Leonard (9)
Kimmel, Seymour S. (21)
Kinczel, John A. (11)
King, Alden P. (14)
Kingma, John G. (2)
Kingslow, George L. (2)
Kinley, John W. (7)
Kinney, Albert G. (4)
Kinney, Burton O. (16)
Kirkby, Cyril S. (7)
Kirkman, Leroy G. (7)
Kirkwood, Allan S. (7)
Kirschner, Martin I. (19)
Klapper, Lester L. (20)
Klarich, Philip (4)
Kleiber, Estelle E. (12)
Klein, Allan (9)
Klein, Andrew J. V. (7)
Klein, Edward C., Jr. (7)
Klein, Edward F. (12)
Klein, Julius (9)
Klein, Milton (14)
Klein, Solomon (14)
Klein, William (12)
Kleiner, Samuel (16)
Kleinman, Maurice (7)
Kleinmann, Eberhart H. (16)
Klempner, Paul (11)
Klenk, Joseph P. (7)
Kler, Joseph H. (12)
Kline, George L. (7)
Kline, Herman (1)
Kline, Joseph J. (11)
Kline, Oram R. (4)
Klinger, John S. (4)
Kloby, John J. (20)
Klompus, Irving (18)
Klosk, Emanuel (7)
Klosterman, Julius A. (2)
Klostermyer, Louis L. (7)
Klughaupt, Dorothy K. (16)
Knapp, Richard E. (2)
Knapp, Victor (13)
Knauer, Charles H., Jr. (11)
Knauer, George (20)
Knight, Augustus S. (18)
Knight, Richard vanD. (20)
Knight, William T. (2)
Knowles, George M. (2)
Knowles, James S. (6)
Knox, Charles A. (2)
Knox, Harriet L. (2)
Knox, Howard A. (10)
Kobes, John J. (7)
Koch, James (7)
Koch, William (13)
Koeck, George P. (7)
Koelsch, Frederick J. (12)
Koenig, Bertram (16)
Koenig, Robert E. (12)
Koerber, George (16)
Kohn, Joseph J. (11)
Kohn, Leo (7)
Kohn, Ralph B. (11)
Kohut, George J. (12)
Kolb, John M. (9)
Kolbe, Joseph T. (6)
Kolodin, Abraham (7)
Kondor, Joseph S. (11)
Konzelman, Henry J. (20)
Konzelmann, Frank W. (1)
Kook, Sol (9)
Kooperman, Barnett (9)
Kooperstein, Samuel I. (9)
Koplin, Nathaniel H. (11)
Korman, Arnold (16)
Kornfeld, Werner (7)
Kornfield, Norman B. (9)
Kosminsky, Louis (9)
Kossmann, Walter J. (14)
Kosterlitz, Henry H. (7)
Kovaleski, Walter A. (16)
Kovin, Abraham (16)
Kraemer, Manfred (7)
Kraemer, Samuel H. (9)
Krafchik, Louis L. (12)
Kraissl, Cornelius J. (2)
Kraker, David A. (7)
Krakower, Alvin H. (16)
Kramer, Bernard M. (12)
Kramer, Douglas W. (20)
Kramer, Samuel E. (12)
Krans, Edward S. (20)
Krasnitz, Alexander (3)
Kratka, William H. (6)
Krauss, Fletcher I. (14)
Krausz, Emery (21)
Kraut, Arthur M. (9)
Krechmer, Abraham (1)
Kren, Frank (11)
Kresch, Philip (9)
Kreutz, Paul J. (20)
Krichbaum, Carroll E. (7)
Kristal, John (2)
Krohn, Marc (13)
Krone, William F. (7)
Krug, Alfred J. (7)
Kruger, William (7)
Krugman, Benjamin M. (16)
Kuchlewski, Edward J. (20)
Kuder, Joseph M. (3)
Kuhlmann, Alvin E. (9)
Kuite, George B. (14)
Kummel, Max (7)
Kump, Albert B. (6)
Kun, Bertram (9)
Kunz, Harold G. (7)
Kuperman, Henry L. (7)
Kurtz, Geza R. (9)
Kushner, Alexander (20)
Kustrup, John F. (11)
Kutner, Charles (4)
Kyhos, Emma D. (7)
Kyle, Ernest I. (20)

ASSOCIATE MEMBERS

Kandle, Roscoe P. (11)
Kant, Emanuel R. (12)
Katzenbach, C. Buckman (11)
Kawalek, Roman (7)
Kenny, James (7)
Kerr, Andrew D., Jr. (16)
Klein, Michael (7)
Kluft, Jack M. (12)
Knowles, Frederick (13)
Kollmar, Robert (7)
Koralek, Adolph H. (7)
Korbonits, Charles W. (13)
Kremer, Leonard (16)
Krudener, Robert D. (2)
Kuhn, Richard E. (16)
Kulick, Morton (16)
Kunderman, Philip J. (12)

L

ACTIVE MEMBERS

Laauwe, Harold W. (16)
La Barba, Peter J. (2)
Labow, Joseph J. (20)
Ladas, George (20)
Lafferty, Elton B. (7)
Lakiszak, Roman T. (9)
Lamberto, Vito A. (2)
Lance, Elton W. (20)
Landaw, Louis (16)
Landes, Edwin W. (19)
Landesman, William (7)
Landis, Harry P., Jr. (3)
Landry, Ernest J. (20)
Landshof, Charles A. (9)
Lane, Edgar W. (10)
Lane, Milton (20)
Lane, Thomas F. (9)
Lang, Joseph (12)
Lang, Joseph T. (12)
Lang, Louis (20)
Lang, Paul (6)
Lang, Richard E. (16)
Lange, Louis C. (9)
Langston, Junius T. (20)
Lapin, Louis P. (11)
Lapin, Mathew R. (11)
Larkey, Irving G. (7)
Larkin, Michael J. (11)
La Rosa, Frank J. (8)
Larossa, Ernest A. (4)
Larrabee, Callie H. (20)
Larson, Henry M. (14)
Larsson, Evert A. (11)
Lathrop, Frederic W. (20)
Lathrope, George H. (14)
Latona, Joseph A. (2)
Laudig, Guy H. (14)
Laufenberg, Joseph W. (11)
Laurusonis, John (8)
Lavine, Barney D. (11)
Lavine, Samuel C. (12)
Lavine, Sidney B. (11)

Lawless, Edward T. (16)
Lawrence, Arthur C. (16)
Lawrence, Elias D. (16)
Lawrence, William H. (20)
Lawsing, G. Conde (9)
Lawther, Boyd M. (1)
Lazow, S. Manlius (12)
Leach, John E. (16)
Leaman, Granville M. (7)
Leaver, Morris H. (10)
Le Bel, Louis J. B. (7)
Leber, Otto H. (7)
Ledden, Lewis J. (11)
Lee, Benjamin F. (4)
Lee, Frederick P. (16)
Lee, John J. (7)
Lee, Robert E. (7)
Lee, Thomas B. (4)
Lee, William A. (9)
Leeds, Leonard W. (7)
LeFavor, Dean H. (3)
Leff, Abraham (7)
Leff, Charles O. (7)
Leff, William A. (7)
Lefkovics, Sidney C. (7)
Lefkowitz, Jacob H. (9)
Legato, Samuel F. (2)
Legg, George E. (16)
Leggett, Lindley H., Jr. (20)
Leggett, Thomas H., Jr. (20)
Lehmacher, Frank (15)
Lehman, David J., Jr. (7)
Lehmann, Otto (13)
Leibovitz, Altan C. (16)
Leir, J. Krevin (9)
Lemay, Albert T. (16)
Lemkin, Samuel (7)
Lemmerz, Willard H. (2)
Lemmon, Junius M. (21)
Lempke, Richard J. (9)
Leon, Jerome L. (7)
Leon, Maurice J. (7)
Leonard, Bernard (3)
Leonard, George F. (12)
Leonard, Isaac E. (1)
Leonard, Isaac E., Jr. (1)
Leonard, Lothair L. (13)
Leone, Peter P. (20)
Lepis, A. Albert (9)
Lepree, Joseph A. (20)
Lerman, Frederick (20)
Lerman, Irving (20)
Lerman, Samuel (20)
Leshin, Harry (11)
Lesko, Stephen W. (2)
Lettiere, Anthony J. (11)
Leuzzi, Darwin A. (9)
Levendusky, Daniel E. (14)
Levin, Jack (13)
Levin, Joseph (7)
Levin, Murray (7)
Levine, David B. (16)
Levine, Edward P. (7)
Levine, G. Irving (9)
LeVine, Israel (16)
Levine, Philip (7)
Levine, Sidney C. (16)
Levinsohn, Sandor A. (16)
Lewis, Alice B. (2)
Levinson, David M. (7)
Levinson, Louis J. (7)
Levinson, Reuben (12)
Levinson, Robert M. (7)
Levison, William (7)
Levitas, George M. (2)
Levitas, Irving M. (2)
Levitov, Leo (9)
Levitt, Jesse N. (7)
Levy, Abram (18)
Levy, Anna L. (7)
Levy, David (16)
Levy, Herman (16)
Levy, Irvin (11)
Levy, Jack D. (2)
Levy, Julius (7)
Lewandowski, Edmund E. (7)
Lewin, Leo (14)
Lewis, Albert (20)
Lewis, Alexander (20)
Lewis, Collins E. (12)
Lewis, G. Rae (7)
Lewis, Jacob (13)
Lewis, Robert L., Jr. (20)
Lewis, Sydney B. (11)
Liana, Stephen M. (16)
Liccese, Emanuel (7)
Licks, Frederick C. (7)
Liddell, Raymond N. (18)
Lieb, Robert L. (7)
Lieb, Saul (7)
Lieberman, David P. (20)
Lieberman, Milton L. (20)
Lieberson, Leonard (9)
Lief, Lawrence H. (12)
Liegner, Ben (7)
Light, Arthur B. (11)
Lilien, Bernard B. (7)
Lilien, Milton (7)
Lilien, Milton M. (20)
Lima, John G. (16)
Linares, A. Carfi (16)
Lincoln, Jennings S. (7)
Lind, Zoltan H. (12)
Linden, Mortimer H. (9)
Lindroth, Lawrence V. (9)
Linke, James J. P. (20)
Lintz, Sidney Z. (8)
Linz, Curt (7)
Lione, John G. (9)
Lipkin, Isadore (17)
Lippman, Harold (7)
Lippman, Nathan L. (1)
Lipshutz, Benjamin (9)
Lipshutz, Charles (9)
Lipstein, William (7)
Lipton, Louis (16)
Lisanti, Gaetano (9)
Little, Alonzo W. (9)
Little, Rufus R. (2)
Little, William R. (11)
Littwin, Charles (2)
Litwer, Herman (9)
Liva, Arcangelo (2)
Liva, G. Albin (2)
Liva, Paul F. (2)
Liva, Vinicio G. (2)
Livengood, Baxter A. (8)
Livengood, Horace R. (20)
Livingston, Bernard (7)
Livingston, Elias (7)
Livingston, Paul (7)
Livingston, Sydney R. (20)
Lloyd, Samuel J. (11)
Llull, Gabriel J. (20)
Lobban, Robert B. (9)
Lobsenz, Nathan P. (16)
Locke, Henrik W. (4)
Loder, Horace B. (6)
Loder, Joseph S. (7)
Loeser, Lewis H. (7)
Lohman, Herman (7)
Loman, Samuel G. (2)
Lomauro, James R. (16)
Lombardi, Frank L. (2)
Lombardo, Bartlo (7)
London, Isabel M. (12)
London, Jules R. (16)
London, Leslie (16)
London, William (12)
Londrigan, Joseph F. (9)
Londrigan, Joseph F., II (9)
Long, Elias E. (13)
Long, John F. (7)
Long, Miles T. (9)
Long, Pauline A. (12)
Longnecker, John E., Jr. (19)
Longo, James J. (7)
Longsdorf, Harold E. (3)
Longshore, Walter E., Jr. (7)
Loori, William A. (9)
Lord, C. Donald (2)
Lore, Harry E. (6)
Losada, Camella A. (20)
Love, Elizabeth F. (3)
Lovell, John F. (7)
Lovett, Irving K. (13)
Lovett, Joseph C. (4)
Low, Donald B. (16)
Lowe, Louise (2)
Lowell, Milton E. (20)
Lowenberg, Robert I. (20)
Lowenstein, Aaron (7)
Lowenstein, Ernest C. (20)
Lowenstein, Harry A. (7)
Lowits, Otto (7)
Lowrey, James H. (7)
Luban, Benjamin (7)
Luca, Frank (13)
Luca, Mildred O. (13)
Lucas, Stanley L. (1)
Lucas, W. Fred (3)
Luce, Henry A. (7)
Lucent, S. Bell (16)
Lucey, James J. (12)
Luczynski, Edward W. (9)
Luddecke, Hugh F. (14)
Lueddecke, Roland E. (2)
Lufburrow, Charles B. (20)
Luippold, Eugene J., Jr. (14)
Luksteid, Casimir J. (16)
Lundblad, Walter E. (7)
Luongo, Federico (7)
Lupin, Edward E. (9)
Lurie, Wolf (7)
Lushear, Frank H. (19)
Lussier, Georges H. (13)
Lustig, Melvin (7)
Lutz, William M. (7)
Lyerly, James M. (20)
Lynch, Albert E. O. (7)
Lynch, Donald C. (11)
Lynch, Edward T. (20)
Lynch, James F. (9)
Lynch, Maurice M. (2)
Lynch, Michael F. (20)
Lynch, Roland J. (9)
Lynn, Hugh B. (7)
Lynn, Irving I. (9)
Lyon, Archibald (7)
Lyon, Earl C. (6)
Lyons, James V. (7)
Lyons, Romola L. K. (2)

ASSOCIATE MEMBERS

Langgaard, Charles (7)
Law, Harrison E. (2)
Leonard, Martha F. (12)
Levine, Burton (7)
Levinstone, Bertram (7)
Levy, Bernard (7)
Lotman, Harry (7)
Lynch, Cornelius G. (11)

M

ACTIVE MEMBERS

Maas, Max A. (7)
Mabee, John R. (16)
Mabey, J. Corwin (7)
MacAlpine, Kenneth B. (4)
Macaluso, Dominic C. (7)
MacArt, J. Harold (7)
MacArthur, Clymont (7)
Macaulay, Francis A. (2)
Macchia, Benjamin J. (9)
MacDermid, Lynden E. (11)
MacDonald, Edward O. (20)
Macdonald, Wentworth S. (7)
MacGahan, William H. (16)
MacGregor, Allan W. (16)
MacGuffie, Robert N. (16)
MacKellar, James M. (2)
MacKenzie, Robert A. (13)
Mackes, Claude B. (17)
Mackin, John J. (9)
Mackler, Harry S. (20)
Mackler, Meyer E. (16)
MacLaren, Philip J. (2)
Maclay, Joseph A. (16)
MacMillan, C. Wright (7)
MacNeal, Perry S. (3)
MacPherson, Elwood H. (7)
Madaras, John S. (9)
Mader, A. Ivan, Jr. (2)
Madi, Risley J. (6)
Madison, L. Keith (9)
Maffeo, Carl E. (7)
Maffongelli, Joseph A. (16)
Magee, Edward S. (4)
Magee, Harold S. (11)
Magee, Russell S. (4)
Magee, William P. (2)
Maggio, George A. (7)
Maggio, Nicholas A. (7)
Maggio, Ross J. (20)
Magill, Marcus (1)
Magnes, Max (16)
Magolda, Anthony F. (6)
Magovern, Thomas F. (7)
Magson, Albert E. (11)
Mahaffey, J. Lynn (4)
Maher, John E. (13)
Mahoney, Francis W. (9)
Mahood, Herbert L. (7)
Mains, M. Paul (11)
Maisel, Irving (7)
Majeski, Henry J. (11)
Major, Morton M. (1)
Makin, John B. (13)
Malatesta, Charles S. (20)
Maldeis, Albertos M. K. (4)
Malinowski, John (9)
Mallison, Herbert (20)
Mamlet, Alfred M. (7)
Mancene, Edward M. (2)
Mancusi-Ungaro, Elviro (7)
Mancusi-Ungaro, Harold (7)
Mancusi-Ungaro, Lodovico (7)
Mandell, Sidney N. (9)
Manette, Milton (9)
Mangelsdorff, Arthur F. (18)
Mangogna, Philip (12)
Mangone, Edith (9)
Manly, Thomas E. (16)
Mann, Benjamin (12)
Mann, Jacob J. (12)
Manno, Peter D. (9)
Manrodt, Kurt, Jr. (16)
Manser, Ernest E. (4)
Mansfield, Richard (9)
Manzione, Frank A. (16)
Marcarian, Henry G. (4)
Marchione, Nicholas E. (6)
Marcus, Bernard (18)
Marcus, Donald (7)
Marcus, Kurt (9)
Margaretten, Edward I. (12)
Margolin, Samuel J. (9)
Margolis, Alfred (7)
Margulies, Charles (7)
Marin, Robert B. (7)
Marini, Dominick (16)
Marino, Benjamin (12)
Mark, Harold I. (2)
Mark, Harry B. (3)
Mark, Joseph S. (12)
Markel, Albert G. (16)
Markley, Luther A. (2)
Markowitz, Benjamin B. (9)
Markowitz, Irwin B. (9)
Markowitz, Isidor (5)
Markowitz, Louis (16)
Marks, Zelda I. (7)
Marlett, Neumann C. (21)
Marone, Carmine R. (20)
Maroney, James H. (20)
Marquis, Dean W. (7)
Marquis, W. James (7)
Marra, Rocco S. (7)
Marrella, Louis F. (9)
Marrocco, William A. (16)
Marshall, Frank A. (9)
Marshall, H. Donald (1)
Martin, Francis E. (21)
Martin, Leonard J. (13)
Martin, Theodore (16)
Martin, William E. (20)
Marts, George H. (20)
Marvel, Peter H. (1)
Marvel, Philip, Jr. (1)
Marvin, Dorothy H. (12)
Marx, Frederick J. (2)
Masciocchi, Thomas A. (7)
Masiello, Carmine J. (9)
Mason, Alvin S. (17)
Mason, James H. (1)
Mason, Stuart A. (2)
Mason, Virgil A. (7)
Massengill, Fulton (7)
Massey, J. Bruce (7)
Masterson, John F. (7)
Mastroianni, Frank M. (20)
Mastromonaco, Joseph D. (9)
Masucci, Alberico (16)
Matheke, George A. (7)
Matheke, Otto G. (7)
Matheke, Otto G., Jr. (7)
Mathesheimer, Jacob L. (9)
Matheson, Gilchrist E. (7)
Mathews, Raymond H. (14)
Mathews, William J. (9)
Matthews, Clifford B. (7)
Matthews, Leonard M. (16)
Matthews, William (13)
Matthews, William F. (7)
Matturri, Dominick A. (9)
Maturi, Vincenzo E. (9)
Mauer, Richard E. (7)
Maurer, K. Virginia (7)
Maurer, Martha E. (20)
Maver, William W. (9)
May, Ernst A. (7)
Mayer, David M. (2)
Mayhew, Charles H. (6)
Mazur, Edward F. (3)
Mazzotta, Samuel (5)
McAfoos, Louis G., Jr. (4)
McAlpine, Paul (20)
McAveney, Thomas F. G. (7)
McBride, Andrew F., Jr. (16)
McCall, Jesse (19)
McCallion, William H. (20)
McCarroll, E. Mae (7)
McCarron, James A. (9)
McCarthy, Arthur M. (4)
McCarthy, George L. (16)
McCarthy, John J. (9)
McCarthy, William P. (11)
McCauley, Francis J. (7)
McClintock, Elsie (20)
McConaghy, Thomas P. (4)
McCormack, Frank C. (2)
McCormick, James E. (7)
McCormick, William H., Jr. (12)
McCracken, Josiah C., Jr. (1)
McCreight, David W. (13)
McCroskery, James H. (7)
McCue, John B. (16)
McCullough, Walter A. (7)
McCurdy, Robert G. (13)
McDermott, Vincent T. (4)
McDonald, Richard J. (16)
McDonnell, George J. (13)
McFeely, Percy R. (2)
McGahn, Joseph (1)
McGeary, John A. (20)
McGeehan, Stanley M. (1)
McGinn, William J. (20)
McGlade, Thomas H. (4)
McGovern, John F., Jr. (12)
McGovern, Patrick J. (9)
McGreevey, Harold (13)

McGuigan, Francis A. (11)
McGuinn, William B. (7)
McGuire, John J. (7)
McGuire, William A. (8)
McIlveen, Marion (2)
McKeever, William J. (9)
McKelvey, Augustus J. (7)
McKelvie, Julius C. (13)
McKeown, George H. C. (7)
McKiernan, Robert L. (12)
McKim, William F. (7)
McKinley, C. Scott (18)
McKinstry, John W. (12)
McLane, A. Donald (2)
McLaughlin, William B. (7)
McLean, Hugh A. (9)
McLellan, George A. (7)
McLeod, Harry J. (2)
McLeod, Neill S. (12)
McLoughlin, Frank J. (9)
McLoughlin, John W. (9)
McMahon, Bernard C. (14)
McMurtrie, William A. (14)
McNeely, Julia A. (7)
McNenney, Claudio E. (9)
McPherson, Malcolm E. (16)
McTague, Robert S. (13)
McVay, Edward A. (7)
McVeigh, Charles J. D. (19)
McWhorter, John E. (2)
McWilliams, Charles E. (4)
Means, Paul B. (11)
Mears, William G. (2)
Mecray, Paul, Jr. (4)
Mecray, Paul M. (4)
Medd, John C. (7)
Meehan, George E. (9)
Meehan, Martin M. (7)
Meeker, Irving A. (7)
Meeker, John L. (20)
Meer, Nadhim E. (16)
Megibow, Harold J. (2)
Meier, William U. (16)
Meineke, William C., Jr. (20)
Meinhard, Fred (7)
Meinzer, Martin S. (12)
Meisel, David B. (7)
Mele, Vincent (7)
Mellen, Stanley H. (7)
Meloney, Lester F. (16)
Meltsner, Louis (9)
Meltzer, Louis (9)
Melvin, Daniel G. (14)
Menden, Julian (14)
Mendenhall, Clinton D. (3)
Meneve, Alfred D. (16)
Menge, Carl H. (15)
Menk, Paul E. (7)
Mensch, Harvey G. (20)
Merendino, Anthony G. (1)
Merk, Anthony (7)
Merkelbach, Walter P. (7)
Merliss, Eugene (7)
Merlo, Francis A. (20)
Merlo, Francis V. (20)
Mermod, Camille (7)
Merrill, Edwin D. (10)
Merselis, John G. (7)
Mersheimer, Christian H. (9)
Messina, Thomas (7)
Metsky, Joseph (7)
Metz, Henry (2)
Metzer, Emma P. W. (3)
Metzer, Freeman W. (3)
Meurlin, Alfred (7)
MeVay, James C. F. (1)
Meyer, Eugene A. (4)
Meyer, George P. (4)
Meyer, Howard M. (2)
Meyer, William (9)
Meyers, Francis R. (16)
Meyerson, Noah (9)
Mezzetti, Alfred F. (6)
Michell, George E. (21)
Michelson, Henry (16)
Mickewich, Stephen A. (9)
Miele, Frank A. (13)
Milanesi, Armand M. (9)
Milano, Cesare A. (1)
Miller, Earle K. (11)
Miller, Eugene L. (7)
Miller, George M. (20)
Miller, Gerald H. (11)
Miller, Herbert G. (2)
Miller, Herman P. (7)
Miller, I. Irwin (7)
Miller, Joseph A. (7)
Miller, Max H. (9)
Miller, Nathan (7)
Miller, Ralph (7)
Miller, Raymond E. (11)
Miller, Reginald C. (11)
Miller, Robert B. (9)
Miller, Robert M. (20)
Miller, S. David (12)
Miller, Samuel R. (11)
Miller, William H. (17)
Milligan, Robert S. (20)
Milliser, Estelle T. (20)
Mills, Charles S. (3)
Mills, Clifford (14)
Minard, Edwy L. (7)
Minier, Carl L. (7)
Miningham, William D. (7)
Minnefor, Charles A. (7)
Minschwaner, Geo. G., Jr. (11)
Mintz, Alvin R. (14)
Miranti, Paul J. (9)
Mishler, Jay E. (1)
Misko, Albert (18)
Missonellie, William (16)
Mitchell, Augustus J. (7)
Mitchell, Charles H. (11)
Mitchell, Charles R. (16)
Mitchell, Walter L., Jr. (7)
Mitchell, Willis B. (15)
Mitskas, Theodore V. J. (11)
Modarelli, Walter H. (9)
Modeski, Chester J. (7)
Modrys, Walter F. (2)
Moeckel, Clarence W. (7)
Mohair, John P. (13)
Mohr, Frank L. (20)
Moir, John A. (5)
Molitch, Matthew (1)
Monaco, Dante P. (7)
Monaco, Saverio A. (7)
Monaloy, Morris A. (16)
Moncada, Salvatore (7)
Monica, Louis A. (9)
Monosson-Friedland, Ida (5)
Monte, Thomas D. (7)
Moolten, Sylvan E. (12)
Moon, Alexander C. (5)
Moon, Dabney vonK. (20)
Moore, Dean C. (7)
Moore, J. Leonard (11)
Moore, Ralph L. (8)
Mores, Herbert R. (2)
Moress, Edward J. (7)
Moretti, John J. (7)
Morgan, Browne (7)
Morganstein, Louis K. (9)
Moriarty, John F. (9)
Morici, Theodore (16)
Moriconi, Albert F. (11)
Morley, Grace C. (9)
Morrill, James P., Jr. (16)
Morris, Carlyle (12)
Morris, David G. (9)
Morris, Karl E. (20)
Morris, Nathan (18)
Morris, Thomas M. (20)
Morris, Watson B. (20)
Morrison, Frederick H. (19)
Morrow, J. Lloyd (16)
Morton, Thomas V., Jr. (7)
Moscoe, Harry A. (16)
Moss, Jack W. (2)
Mott, Joseph E. (16)
Motzenbecker, Peter F. (7)
Motzenbecker, William J. (7)
Mountford, William E. (11)
Muccia, John J. (9)
Mueller, George H. (9)
Mulford, William P. (3)
Muller, Frederick L. (2)
Mulligan, Edward W. (13)
Mulligan, Luke A. (2)
Mullin, Raymond J. (7)
Mulvihill, William J. (9)
Munro, Charles A. (3)
Munro, Jeannette (11)
Murn, Charles J. (16)
Murphy, Arthur G. (7)
Murphy, Herschel S. (20)
Murphy, James A. (11)
Murphy, James M. (9)
Murphy, Leo J. (9)
Murphy, Patrick H. W. (9)
Murphy, Thomas W., Jr. (7)
Murray, Clifford K. (1)
Murray, Edwin N. (4)
Murray, Harrold A. (7)
Murray, Joseph A. (9)
Murray, Norman L. (20)
Murto, Thomas V. (11)
Musetto, Carmelo A. (14)
Mustermann, Otto H. (9)
Musulin, Nicholas R. (4)
Muttart, George W. (9)
Mutter, Alfred A. (9)
Myatt, Leslie E. (6)
Myers, Norman V. (2)

ASSOCIATE MEMBERS

Malis, Leonard I. (1)
Marucci, Horace D. (7)
Mason, John T., Jr. (7)
Mather, William B. (11)
McCormack, Raymond A. (11)
McCroskery, Hamilton M. (7)
McKinney, Thomas S. (2)
Meehan, James S., Jr. (2)
Merliss, Harry (7)
Migliori, Angelo (11)
Miller, Clark F. (12)
Moore, William J. (11)
Morgenstern, Mates (12)
Movelle, John (13)
Mulberg, Harry (7)
Murray, Edward F. (7)
Myer, Clifton G. (12)

N

ACTIVE MEMBERS

Nacca, Carl A. (7)
Naclerio, Amedeo (2)
Nadel, Charles I. (7)
Nafash, Shafeek (9)
Nafey, Herbert W. (12)
Naidorff, Saul A. (20)
Nappi, Pasquale E. (7)
Nash, Alexander E. (7)
Nash, Herman S. (7)
Nataro, Maurice (7)
Nathanson, Norman (13)
Naulty, Charles W., Jr. (12)
Navazio, Attilio (14)
Nayfield, Ronald C. (11)
Neal, Charles B. (6)
Neals, Huerta C. (9)
Neander, David G. (17)
Nelson, Francis B. (20)
Nemiroff, Nathan (2)
Nemirow, Martin (16)
Nemzek, William P. B. (7)
Nesbitt, Elizabeth (16)
Nestor, John (19)
Netz, Lester W. (2)
Neumann, Alfred (20)
Nevins, Thomas F., Jr. (20)
Nevius, John K., Jr. (20)
Nevius, William B. (7)
Newbury, Graham C. (20)
Newcomb, Marcus W. (3)
Newcomer, Harry S. (5)
Newman, Grace T. (7)
Newman, Julius (7)
Newmann, Monroe E. (2)
Newmeyer, Joseph (4)
Ney, J. Marshall (7)
Nichols, Stanley H. (13)
Nicholson, Frank P. (9)
Nickman, E. Harrison (1)
Nicol, Lorenz C. (2)
Nicola, Toufick (7)
Nicoll, George L. (14)
Nieman, Solomon Z. (12)
Nimaroff, Meyer (7)
Nittoli, Rocco M. (20)
Nobile, James J. (9)
Noll, Louis (7)
Nonziato, Frank A. (11)
Normand, Alphonse F. (12)
Norris, Alfred W. (16)
Norton, James F. (9)
Norval, William A. (16)
Norwich, Louis E. (9)
Notkin, Meyer (16)
Novello, Joseph A. (20)
Novich, Max (7)
Nussbaum, Harvey E. (7)
Nussbaum, Joseph (20)
Nussbaum, Nathan (16)
Nyiri, William A. (7)
Nyvall, Pierre J. (15)

ASSOCIATE MEMBERS

Naame, John M. (1)
Nataro, Jerome D. (7)
Nichols, Joseph E. (7)
Niemiera, Alexander K. (12)
Nimaroff, Harold (7)
Novak, John G. (7)
Nutzel, Leon P. (7)
Nuzzolo, Charles A. (16)

O

ACTIVE MEMBERS

Oberlander, Gertrude (7)
Obert, J. Edwin (15)
Obester, Gabriel E. (20)
O'Brian, Dennis M. (16)
O'Brian, Jeremiah H. (16)
O'Brien, Edwin J., Jr. (20)
Ockene, Abraham (9)
O'Connell, James J. (12)
O'Connor, Bernard A. (7)
O'Connor, Dennis F. (7)
O'Connor, John J. (9)
O'Connor, Michael J. (7)
O'Connor, Paul A. (7)
O'Crowley, Clarence R. (7)
Oderr, Charles (20)
Oesterreicher, Desider (9)
Oestreicher, Harry (14)
Offenkrantz, Frederick M. (16)
Ogden, Andrew E. (11)
Ogden, Michael A. (16)
O'Grady, Michael J. (7)
O'Hanlon, George (9)
Okin, Irving (16)
Olini, Joseph J. (7)
O'Lini, Louis J. (7)
Olpp, Archibald E. (9)
Olpp, John L. (2)
Olson, Vendela E. (2)
Ondovchak, M. Frederic (4)
O'Neill, Charles L. (7)
O'Neill, Charles L., Jr. (7)
O'Neill, Joseph F. (11)
Onorato, Vincenzo R. (7)
Opdyke, Gordon M. (7)
Openchowski, Mieczyslaw (7)
Opper, Philip (16)
Oram, Joseph H. (16)
Oransky, Marvin (7)
Oren, Hyman (2)
Orloff, Samuel (7)
Ormsby, Thomas J. (7)
Ornaf, I. Edward (4)
O'Rourke, James J. (11)
Orris, Harold J. (7)
Ortolano, James J. (9)
Orton, Foster (20)
Orton, George L. (20)
Orton, Henry B. (7)
Orton, Stuart (20)
Osborn, A. Downey (13)
Osborn, Edward G. (4)
O'Shea, John J. (9)
Osher, Morris M. (20)
Oshrin, Henry (9)
Ostrowski, Sigismund J. (7)
O'Sullivan, John R. (9)
Outwin, Richard N. (7)
Owen, Philip (20)
Ozier, Charles W. (16)

ASSOCIATE MEMBERS

Orlando, Lorenzo (2)
Ott, Franklin B. (7)

P

ACTIVE MEMBERS

Padden, Aloysius F. (2)
Paddock, Royce (7)
Padney, Edward V. (9)
Pagano, Peter (2)
Pagliughi, John J. (9)
Paisley, Ellwood S. (4)
Palazzo, William L. (14)
Palin, George (20)
Palladino, Alessandro (6)
Pallen, Conde deS. (2)
Palma, Nicholas (16)
Palmer, Francis R. (16)
Palmer, Gideon H. (7)
Palmer, Henry S. (7)
Palmeri, Anthony (16)
Palmisano, Vincent S. (4)
Panigrosso, Louis R. (12)
Panitch, William (7)
Pannullo, John N. P. (7)
Pansy, Abraham A. (12)
Pantaleone, Joseph (11)
Papera, John J. (7)
Parell, George C. (7)
Parent, Sol (7)
Paris, William (16)
Parker, John E. (7)
Parker, Paul (11)
Parry, Allen A. (14)
Parry, Antoinette R. (14)
Parry, Oliver K. (13)
Parsonnet, Aaron E. (7)
Parsonnet, Eugene V. (7)
Pascall, Thomas M. (7)
Pasternack, Elroy (16)
Pastore, Mario (6)
Patella, Fulvio (16)
Patterson, Isaac N. (8)
Patti, Frank A. (2)
Patton, Paul B. (14)
Pattyson, Ralph A. (7)
Paul, Abraham (1)
Paul, George A. (7)
Paul, H. Carl (7)
Pauly, Arthur N. (18)
Pauncz, A. (18)
Pavia, John R. (7)
Payne, Douglas (13)
Payne, Guy (7)
Payne, Guy, Jr. (7)
Peacock, Arthur B. (3)
Pearl, Sydney S. (20)
Pearlman, Saul J. (16)
Pearlstein, Frank (9)
Peckman, Abram (9)
Pecora, Carmine L. (15)
Pecora, Samuel (7)
Pedevill, Joseph R. (2)
Pedrick, William W. (8)
Peer, Lyndon A. (7)
Pegau, Paul M. (8)
Pellecchia, Leonard J. (7)
Pellegrini, Vincent J. (2)
Pellet, Thomas L. (19)
Pellicane, Anthony J. (12)
Pelliciari, Donald (7)
Penchansky, Samuel (9)
Penchansky, Samuel J. (9)
Pendexter, Sidney E. (7)
Pennington, Alfred W. (7)
Pennington, John (1)
Pentecost, Salvador D. (7)
Pentel, Louis S. (9)
Pepe, Salvatore A. (11)
Perez, John F. (1)
Perham, Bertram S. (7)
Perham, Roy G. (2)
Perkel, Louis L. (9)
Perlberg, Harry J. (9)
Perlmutter, Irving K. (7)
Permison, Michael (7)
Pernetti, Anthony M. (16)
Perrine, Cornelius C. (13)
Perrone, Anthony J. (7)
Perrone, Arthur F. (9)
Perrotta, Anthony J. (13)
Perry, Frank L. (17)
Pessel, Johannes F. (11)
Peters, Edgar A. P. (9)
Peters, Richard C. (20)
Peterson, Charles A. (9)
Peterson, Walter R. (11)
Petinga, Thomas J. (1)
Petrone, Peter A. (7)
Petry, William (7)
Pettit, Harry H. (2)
Pettit, Herschel (5)
Pettit, Paul H. (5)
Pfeffer, Burton B. (16)
Phelan, Walter F. (20)
Phelps, James E. (16)
Phillips, Algernon A. (7)
Phillips, Claude B. (4)
Phillips, Ralph S. (6)
Phillips, Walter (2)
Piampiano, John (19)
Piasecki, Chester A. (16)
Picardi, Armand A. (7)
Pieper, Howard C. (13)
Pierson, Carl L. (11)
Pierson, Joseph R. (11)
Pietri, Raoul (13)
Pignataro, Frank P. (13)
Pike, Charles E. (4)
Pilch, Arthur G. (7)
Pilkington, Albert (1)
Piller, Jacob (16)
Pilloni, Louis (7)
Piltz, George F. (9)
Pinckney, Frank H. (14)
Pincus, Isidore (7)
Pindar, Arthur W. (2)
Pindar, Frederick S. (9)
Pindar, Irene D. (2)
Pindar, William A., Jr. (2)
Pinerman, Robert B. (11)
Pingitore, Eufelia (2)
Pink, Solomon H. (16)
Pino, Anthony (6)
Pinsky, Harry A. (4)
Pinto, Joseph A. (7)
Piskorski, Abdon V. (9)
Pitman, Mason W. H. (18)
Pittman, Allen R. (11)
Pizzi, Francis W. (7)
Pizzi, Mario V. (7)
Plavin, Nathan J. (9)
Pleasants, Edward N. (13)
Plinke, Fritz W. (16)
Plume, Clarence A. (14)
Podell, A. Alfred (13)
Pogge, Raymond C. (20)
Pogoloff, Samuel H. (18)
Pogue, Elbert H. (20)
Pois, John (7)
Poland, George A. (1)
Poleshuck, Rubin (20)
Policastro, Nelson C. (2)
Polizzotti, Joseph L. (16)
Polk, Charles C. (20)
Pollack, Louis (20)
Pollack, Roy (2)
Pollack, Sol (20)
Pollak, Berthold S. (9)
Pollard, William E. (11)
Poller, Frederick K. (7)
Pollis, Nicholas L. (7)
Pollock, Samuel L. (7)
Pollock, Theodore (16)
Polow, Benjamin (7)
Polowe, David (16)
Pomeranz, Raphael (7)
Pons, Carlos A. (13)
Pontery, Herbert B. (9)
Potter, Benjamin P. (9)
Potter, Charles W. (21)
Potter, Ellen C. (11)
Potter, Raymond T. (7)
Pottinger, William E. (14)
Povalski, Alexander W. T. (9)
Powell, Robert J. (1)
Powis, Ethel M. (11)
Poyas, Morton L. (11)
Prager, Bert A. (14)
Prall, Henry E. (2)
Prather, Charles G. (2)
Prather, John W. (2)
Pratt, Arthur G. (4)
Prazak, Beatrice (20)
Preece, John D. (11)
Pregnall, James P. (13)
Preminger, Max (20)
Prestifilippo, Silvestro (7)
Preston, Perry B. (7)
Price, Charles W. (7)
Price, H. Preston (9)
Price, Henry S., Jr. (4)
Prince, Samuel (9)
Principato, Roberto (4)
Probst, Everett W. (7)
Proctor, Francis E. (11)
Proctor, Jesse E. (7)
Protzman, Thomas B. (2)
Proudfoot, Perry A. (20)
Prout, William B. (2)
Provenzano, Samuel (7)
Provisor, Benjamin (16)
Prunetti, Carmen (11)
Pullen, Guy F. (2)
Purcell, Ernest F. (11)
Purdy, Charles H. (9)
Pusin, Max (9)
Putter, Eric (12)
Pyle, Louis A. (9)

ASSOCIATE MEMBERS

Panzer, Norman (7)
Pasquale, Thomas L. (7)
Pasquariello, Peter (16)
Pedicini, Joseph L. (7)
Pendexter, Sidney E., Jr. (7)
Perlman, Maximilian (7)
Philo, Seymour S. (11)
Pickar, Gabriel (12)
Piegari, Felix H. (7)
Pilpel, Michael (7)
Pinck, Bernard (16)
Pisani, Anthony A. (13)

Q

ACTIVE MEMBERS

Quackenbos, Harrie M. (11)
Quad, Clifford W. (7)
Quigley, Frederic J. (9)
Quinn, Edward D. (7)
Quinn, Norman J. (1)
Quirk, Martin A. (13)

R

ACTIVE MEMBERS

Raab, Michael (16)
Raban, Reginald J. (4)
Rabinowitz, Jacob H. (7)
Rachlin, Harry T. (7)
Rachunis, Michael (3)
Racz, George (12)
Rader-Hoheb, Katherine A. (2)
Radest, Louis J. (16)
Rados, Andrew (7)
Raffetto, Joseph F. (13)
Ragany, Joseph (11)
Rainey, Willard G. (11)
Ram, Nathan H. (7)
Rampona, Joseph M. (11)
Rampond, James R. (7)
Ramsey, F. Muriel (6)
Randazzo, Anton P. (16)
Randolph, Andrew J. (20)
Ranson, Briscoe B., Jr. (7)
Rapalski, Adam J. (7)
Raphael, Chester M. (13)
Rapp, Robert F. (4)
Rappaport, Doris I. (2)
Raso, Frank L. (9)
Rathgeber, Charles F. (7)
Rathauser, Frank (11)
Rathmell, Thomas K. (11)
Rattenne, Edward (7)
Rauschenbach, Paul E., Jr. (16)
Ravits, Everett C. (2)
Ravitz, Samuel F. (7)
Rawitz, Sidney B. (7)
Re, Natale M. (2)
Read, Donald B. (9)
Read, Hilton S. (1)
Read, Jessie D. (20)
Read, William T., Jr. (4)
Reading, H. Eugene (16)
Reale, Frank P. (20)
Reale, Nicholas P. (18)
Reason, John J. (12)
Reed, Robert R. (14)
Reeve-Allen, Jane (7)
Reeves, Ernest (16)
Reich, Abraham L. (7)
Reich, Emma (7)
Reich, Henry (7)
Reich, Jerome J. (20)
Reich, Mortimer (7)
Reich, Samuel B. (2)
Reid, Erwin W. (2)
Reilly, Christopher J. (7)
Reilly, David F. (20)
Reilly, John V. (7)
Reilly, Joseph (4)
Reilly, Thomas F. (16)
Reinartz, Paul V. (7)
Reiner, Jacob (20)
Reinfeld, Abraham G. (7)
Reingold, Alexander (9)
Reinhard, Louis (1)
Reinhardt, Warren I. (7)
Reinhold, Herbert E. (2)
Reinhorn, Abraham J. (16)
Reinkraut, Arthur D. (16)
Reisinger, Paul B. (11)
Reissman, Erwin (7)
Reiter, Walter A. (20)
Reitman, Norman (12)
Reitnauer, John S. (2)
Relyea, George M. (20)
Remondelli, Raphael E. (7)
Renna, Francis (14)
Renner, Clara C. (18)
Renzulli, Francesco (7)
Repici, Anthony J. (4)
Repta, Stephen (20)
Resch, Henry U. (7)
Resnick, Nathan (11)
Ressetar, Michael (16)
Restaino, Charles F. (7)
Rettig, Isidor L. (7)
Reyner, Daniel C. (1)
Reynolds, Donald G. (13)
Reynolds, George G. (13)
Reznikoff, Leon (9)
Rhoads, S. Creadick (8)
Rhodes, Harry, Jr. (2)
Rhone, David S. (4)
Ribbans, Robert C. (7)
Riccobono, Cosmo S. (16)
Rice, Franklin W. (14)
Rich, Charles (7)
Rich, Wallace E. (7)
Richards, Ernest W. (2)
Richardson, Charles A. (2)
Richardson, Emma M. (4)
Richardson, Marvin T. (7)
Richlan, Alfred (7)
Richlin, Padie (7)
Ricketts, Henry E. (7)
Rieck, Allan (1)
Riegert, Louis C. (4)
Rieman, Aloysius P. (9)
Riese, Jacob A. (9)
Riffin, Irving M. (7)
Rifici, Anthony L. (13)
Rigeron, D. George (7)
Riggs, Vincent J. (7)
Rineberg, Irving E. (12)
Ringe, Charles L., Jr. (21)
Ringewald, Robert H. (2)
Rinzler, Elliot (7)
Rinzler, Harry G. (16)
Rinzler, Harvey (15)
Riordan, John P. (9)
Ripley, E. Warren (7)
Rise, Wilson S. (1)
Ristine, Edwin R. (4)
Rita, James J. (11)
Ritter, John J. (16)
Rizzolo, Edward M. (7)
Robbin, Lewis (7)
Robbins, Charles M. (7)
Robbins, Eugene (7)
Robbins, Morris A. (3)
Roberts, Allison H. (7)
Roberts, Charles D. (2)
Roberts, David C. (7)
Roberts, Joseph E., Jr. (4)
Roberts, William A. (7)
Robertson, Eugene V. (16)
Robertson, Euston S. (7)
Robertson, Grace M. (20)
Robinson, Aaron J. (11)
Robinson, Ernest A. (13)
Robinson, Louis H. (7)
Robinson, William A. (13)
Rocco, Frank (7)
Rocco, Leo C. (13)
Rodi, Louis M. (1)
Rodman, E. Warren (3)
Roecker, Roland D. (18)
Roemer, Jacob (16)

Rogers, Dorothy M. (8)
Rogers, James A. (16)
Rogers, Laurence H. (11)
Rogers, Robert H. (7)
Roh, Robert F. (7)
Romano, Anthony M. (2)
Romano, Frank (12)
Romano, Michael J. (16)
Romano, Patrick J. (7)
Rona, Maurice (12)
Roop, William O. (1)
Rose, Abraham (20)
Rose, Salvatore J. (7)
Rose, William G. (11)
Roseman, Herman I. (7)
Rosen, Charles D. (7)
Rosen, Charles E. (9)
Rosen, Frank L. (7)
Rosen, Herbert J. (14)
Rosen, Sol (6)
Rosenbaum, Samuel X. (7)
Rosenberg, Albert B. (9)
Rosenberg, Alvin A. (14)
Rosenberg, Hyman (4)
Rosenberg, Jacob (9)
Rosenberg, L. Charles (7)
Rosenberg, Lillian M. (7)
Rosenberg, Louis (1)
Rosenberg, Max (7)
Rosenberg, Norman (12)
Rosenblatt, Max B. (20)
Rosenblatt, Sidney (1)
Rosenstein, Jacob L. (9)
Rosenstein, Saivel L. (20)
Rosenthal, Abraham (13)
Rosenthal, Arnold J. (7)
Rosenthal, Oscar J. (7)
Rosenthal, Sydney (7)
Rosiello, Louis E. (6)
Rosner, Edwin (4)
Ross, Ira S. (7)
Ross, Peter W. (16)
Rossi, Bartolomeo (18)
Rossi, Gene (18)
Rossi, John R. (9)
Rost, Adolf S. (7)
Roston, Mark A. (7)
Roth, Daniel B. (2)
Roth, Ferdinand L. (7)
Rothberg, Moses (9)
Rothfuss, C. Howard (12)
Rothgesser, Jerome C. (7)
Rothhouse, Burnet (7)
Rothman, Sidney (11)
Rothschild, Daniel L. (7)
Rothschild, Karl (12)
Rothseid, Abraham (7)
Rowan, Henry M. (11)
Rowland, John H. (12)
Rowohlt, George O. (2)
Roy, Bert W. (19)
Roy, Joseph N. (16)
Roylance, F. Dean, Jr. (2)
Rozett, Oscar (20)
Rozsa, Stephen (7)
RuBacky, Joseph F. A. (16)
Rubba, Russell R. (1)
Rube, Joseph A. (2)
Rubens, Otto (14)
Rubenstein, Eli (9)
Rubenstein, Robert (9)
Rubin, Abraham A. (7)
Rubin, Adrian D. (13)
Rubin, Bernard D. (9)
Rubin, David (20)
Rubin, Jacob S. (13)
Rubin, William (12)
Ruccia, Arthur (7)
Rucker, William C. (2)
Rudolph, John P. (4)
Rudomanski, Victor (7)
Ruffer, Ralph A. (9)
Ruggieri, Pasquale (6)
Rullman, Walter A. (13)
Rumage, William T. (7)
Rumsey, William L., Jr. (20)
Rundlett, Emilie V. (9)
Runnells, John E. (20)
Runyan, William J. (7)
Runyon, Laurence P. (12)
Ruocco, William B. (16)
Ruoff, Andrew C. (9)
Ruoff, Andrew C., III (2)
Russell, Charles B. (16)
Russell, Karl S. (4)
Russell, Marie E. (4)
Russillo, Philip (9)
Russo, Dominic T. (18)
Russomanno, Paul (7)
Russomanno, Raymond L. (7)
Ruttenberg, Louis (8)
Ruttenberg, Max (4)
Ruvane, Joseph J. (9)
Ryan, Lawrence W. F. (4)
Ryley, Harold W. (2)
Ryman, Merlin T. (14)

ASSOCIATE MEMBERS

Rasin, Carl (16)
Rath, Morris (7)
Rentrop, Charles A., Jr. (2)
Rich, Robert E. (7)
Ritota, Michael C. (7)
Rizzo, Ettore G. (16)
Robinson, Irving W. (11)
Rosenberg, Marvin (16)
Ross, Bernard (2)
Rothenberg, Friedrich (16)
Rotondi, Leonard J. (7)
Rubin, Sidney (7)
Ruby, Victor M. (1)
Ruggio, Joseph (7)
Rusin, Michael (2)

S

ACTIVE MEMBERS

Sabarese, Theodore C. (16)
Sabini, Cecil F. (9)
Sacco, Anthony G. (9)
Sacco, Gregory E. (13)
Sachs, Fred (9)
Sachs, Wilbert (9)
Sackin, Stanley (11)
Saco, Louis S. (16)
Sadoff, Joseph (20)
Sadusk, Joseph F., Jr. (7)
Saffron, Morris H. (16)
Sager, Harold (9)
Sagert, Carl M. (14)
Sagi, Ellen I. (20)
Sakowski, John P. (9)
Sala, Aldo W. (16)
Saladino, Anthony J. (9)
Salaky, William L. (12)
Salasin, Samuel L. (1)
Salerno, Louis (16)
Salmon, Edward F. (9)
Salsberg, Ralph H. (7)
Salter, Kent (16)
Saltus, Lloyd S. (14)
Salvati, Leo H. (20)
Salvatore, Joseph T. (11)
Salway, Benjamin (11)
Salzman, Nathan (16)
Salzmann, Bertold (9)
Samson, Norman D. (7)
Samuel, Jerome H. (7)
Sand, Abraham B. (3)
Sandella, Joseph F. (12)
Sandler, Moses (2)
Sandler, Samuel A. (2)
Sanfacon, Thomas A. (16)
Sanford, Marcus E. (18)
Santangelo, Emil L. (16)
Santangelo, Stephen (9)
Santora, Philip J. (7)
Santoro, Anthony (16)
Santoro, Thomas A. (7)
Saporito, Archibald R. (7)
Saracino, Frank J. (7)
Saradarian, Albert V. (9)
Sarajian, Aram M. (2)
Sargent, Eva R. (18)
Sarla, Michael (2)
Sarno, Anthony (7)
Sarokhan, Joseph (16)
Saseen, Charles A. (1)
Saslow, Benjamin I. (7)
Saslow, Stella K. (7)
Sasso, Albert (7)
Satulsky, Emanuel M. (20)
Sauerbrun, Bertram J. L. (20)
Saukimas, John (18)
Saulsberry, Charles E. (12)
Savel, Lewis E. (7)
Sawyer, Blackwell (15)
Sax, Max T. (7)
Sbarra, Francesco C. N. (7)
Scalessa, Mario F. T. (20)

Scanlan, D. Ward (1)
Scasserra, Benedict B. (11)
Scerbo, Ernest (2)
Schaaf, Royal A. (7)
Schaaf, Royal S. (7)
Schaberg, Frank J. (2)
Schaeffer, Alan M. (3)
Schafer, Marguerite A. (16)
Schaffer, Barney (7)
Schaffer, Nathan (7)
Schall, Reuben E. (4)
Schapiro, Morris (9)
Schectman, Vera (7)
Scheer, Ell (2)
Scheffler, Wilhelm A. H. (4)
Schefrin, Alexander E. (16)
Scheiber, Geza (7)
Schellenger, Edward A. Y. (4)
Scheller, George A. (7)
Schenk, Joseph R. (20)
Schenker, Benjamin N. (9)
Schenker, Israel N. (9)
Schenker, Sarah S. (9)
Schept, Samuel S. (9)
Scher, Maurice A. (7)
Schildkraut, Jacob M. (11)
Schiller, Edwin (20)
Schiller, Rosa O. (20)
Schilling, Anthony B. (20)
Schillinger, Raphael (20)
Schimenti, Matteo (9)
Schirber, Rene G. (12)
Schirmer, William (20)
Schisler, Milton M. (3)
Schleifer, Arnold (16)
Schlein, August (9)
Schlein, David (20)
Schlichter, Charles H. (20)
Schlossbach, Theodore (13)
Schlossberg, Ezra (16)
Schmaier, Sica L. (13)
Schmidt, Albert F. (13)
Schmidt, Clifford M. (19)
Schmidt, Walter W. (2)
Schmukler, Jacob (7)
Schneckendorf, Samuel J. (9)
Schnee, Isadore M. (16)
Schneider, Charles A. (7)
Schneider, Clinton R. (15)
Schneider, Harry M. (9)
Schneider, Leonard (13)
Schneider, Louis (7)
Schneider, Louis A. (9)
Schneider, Richard C. (7)
Schoenau, Carl W. (7)
Schorr, Herman E. (9)
Schotland, Clement E. (7)
Schrack, Helen F. (4)
Schram, William S. (7)
Schramm, Joseph A. (7)
Schreck, Harry (7)
Schretzmann, Rudolph C. (2)
Schubert, Roy R. (16)
Schuchner, William F. (9)
Schuck, Traugott J. (9)
Schulsinger, Samuel (7)
Schulte, Herbert A. (7)
Schults, Anna R. (7)
Schultz, Augustin M. (16)
Schultz, Irving A. (16)
Schumacher, Evelyn L. (14)
Schurman, Francis H. C. (7)
Schwab, George P. (9)
Schwartz, Frank (9)
Schwartz, Harold (7)
Schwartz, Harold B. (9)
Schwartz, Henry C. (4)
Schwartz, Jacob R. (16)
Schwartz, Leo (16)
Schwartz, Leon J. (2)
Schwartz, Lewis (9)
Schwartz, Mortimer L. (7)
Schwartz, Ralph A. (7)
Schwartz, Samuel H. (20)
Schwartz, William (16)
Schwartzberg, Frederick I. (16)
Schwarz, Berthold T. D. (9)
Schwarz, Henry J. (9)
Schwarz, John (9)
Schwarz, Julianna L. (16)
Schwarz, Leopold (5)
Schwarzkopf, George C. (1)
Schweizer, Roman G. (20)
Sciarrillo, Louis F. (9)
Scielzo, Nicholas F. (16)
Scillieri, John (16)
Sciorsci, Edward F. (9)
Sciorsci, Mario (9)
Scolamiero, Pasquale (7)
Scott, Frederick J. (19)
Scott, Frederick W. (12)
Scott, Harold R. (7)
Scott, John J. (9)
Scott, Kenneth H., Jr. (20)
Scott, Leonard G. (6)
Scott, Norman M. (7)
Scott, Samuel G. (9)
Scovern, Louis (16)
Scranton, Charles W. (7)
Scribner, Charles H. (16)
Scullion, Arthur A. (2)
Sealey, Henry J. (2)
Seely, Roy B. (11)
Segard, Christian P. (2)
Seiberling, Joseph D. (4)
Seidler, Victor B. (7)
Seidman, Edwin A. (7)
Seidman, Joshua I. (7)
Seidmon, Edward E. (20)
Seifert, Edwin A. (7)
Seiler, Benjamin (2)
Seitzick-Robbins, Hannah E. (11)
Sekerak, Albert J. (11)
Seligmann, Fred S. (9)
Sell, Frederick W. (20)
Sellitto, Anthony M. (7)
Sender, Fannie (12)
Senerchia, Fred F., Jr. (20)
Serri, William S. (8)
Seto, Stanford P. T. (4)
Sevringhaus, Elmer L. (7)
Sewall, Arthur D. (6)
Seward, Frederic H. (14)
Seward, William H. (7)
Sewell, Stephen (13)
Sexton, Edward V. (2)
Seybold, Arthur D. (20)
Seymour, Edward T. (2)
Seymour, George A. (20)
Shack, Maxwell H. (7)
Shaen, Edward (4)
Shafer, Albert H. (4)
Shafer, F. William (4)
Shaner, Ralph D. (7)
Shangle, Milton A. (20)
Shangold, Jack E. (12)
Shanik, Morton J. (14)
Shanik, William (13)
Shannon, James B. (7)
Shannon, Lardner M. (7)
Shapiro, Charles S. (3)
Shapiro, David (16)
Shapiro, Edward E. (9)
Shapiro, Irving (7)
Shapiro, Joseph S. (16)
Shapiro, Louis (7)
Shapiro, Louis G. (16)
Shapiro, Max (20)
Shapiro, Nathaniel J. (9)
Shapiro, Ralph N. (7)
Shapiro, Samuel A. (7)
Shapiro, Saul J. (13)
Shapiro, Sydney H. (7)
Sharbaugh, George B. (11)
Sharp, Charles E. (6)
Sharp, Reuben L. (4)
Shaul, Frederick G. (7)
Shaul, John F. (7)
Shavelson, Irving C. (1)
Shaw, Ernest B. (4)
Shaw, John J. (7)
Shaw, Ned (4)
Shayevitz, Abraham S. (12)
Sheaffer, Clinton P. (4)
Shear, M. Murray (11)
Shechner, Isadore (7)
Shechtman, Abraham (16)
Sheedy, John J. (20)
Sheehan, Daniel C. (7)
Sheeran, Vincent J. (9)
Sheets, Cecil C. (8)
Sheft, Matthew J. (16)
Shemeley, William G., Jr. (4)
Shenfeld, Isaac (1)
Shepard, Morse A. (7)
Shepard, Myron (9)
Sheppard, Alfred G. (6)
Sheppard, Muse A. (6)
Sheppard, Thomas S. (6)
Sherk, A. Lincoln (4)
Sherman, A. Russell (7)
Sherman, Abraham (9)
Sherman, Arthur E. (7)
Sherman, Elbert S. (7)
Sherman, Fuller G. (8)
Sherman, W. Edgar (12)
Shevitz, David M. (21)
Shill, Benjamin (7)
Shimer, Floyd A. (21)
Shinefeld, Maurice A. (16)
Shipman, James S. (4)
Shipman, Meyer P. (16)
Shipman, Robert T. (9)
Shipps, Hammell P. (4)
Shivers, Charles H. deT. (1)
Shlionsky, Herman (7)
Shook, Benjamin E. (9)
Shope, Edward P. (4)
Shor, David M. (7)
Shreehan, Hubert F. (7)
Shull, Elliott C. (4)
Shull, John V. (12)
Shulman, Abraham (16)
Shulman, Murray W. (7)
Shulman, Nathan L. (9)
Shuster, Samuel A. (1)
Sica, L. Samuel (11)
Siclliano, Thomas (16)
Sickel, Emanuel M. (15)
Sleber, Isaac G. (4)
Siegel, Isadore (12)
Siegel, Jack G. (7)
Siegel, Jacob W. (7)
Siegel, Lester (9)
Siegel, Ralph E. (12)

Siegel, Sidney L. (6)
Siegel, Victor (13)
Siegler, Julius (9)
Siemion, Theophilis R. (11)
Sieskind, Richard S. (7)
Sigman, George (9)
Silber, Irving M. (12)
Silberner, Herbert B. (7)
Silich, Robert L. (9)
Silk, Charles I. (12)
Sill, John B. (11)
Silon, Milton R. (9)
Silver, E. Drew (11)
Silver, Michael W. (16)
Silvera, Salomon (9)
Silverman, Irving A. (16)
Silverman, Mendel (2)
Silverman, R. Louis (17)
Silverman, S. Andrew (7)
Silverman, Theodore M. (20)
Silvers, Homer I. (1)
Silverstein, Benjamin J. (7)
Silverstein, Jacob M. (7)
Simeone, Peter A. (9)
Simkin, Abraham (16)
Simmons, Albert V. (7)
Simms, George F. (7)
Simon, Fritz C. (10)
Simon, Henry (7)
Simon, Ludwig L. (7)
Simon, Philip H. (16)
Simonson, Louis (7)
Simpson, David B. (9)
Sims, Richard V., Jr. (20)
Sinderbrand, Robert E. (1)
Sinexon, Henry L. (8)
Singer, Bella (20)
Singer, Marie J. (2)
Singer, Max (7)
Singer, Sina S. (9)
Sinkinson, Charles D., Jr. (1)
Sinnott, Gerald W. (9)
Sirotta, E. Bernard (8)
Siss, Alfred A. (16)
Sisson, Nelson W. (7)
Siwek, Stanley (7)
Skrypski, Joseph M. (9)
Skvarla, John A. (2)
Skwirsky, Joseph (7)
Skyer, Joseph (4)
Slack, Clarence J. (11)
Slaff, Florence (16)
Slavin, Paul (7)
Sloan, Samuel L. (16)
Sloane, Milton B. (2)
Slobodien, Benjamin F. (12)
Slocum, Harry B. (13)
Sly, John L. (20)
Small, E. Lester (3)
Small, Louis (16)
Smalzried, Elmer W. (7)
Smarzo, Marjorie M. (7)
Smith, B. Earl (11)
Smith, Bertram H. (4)
Smith, Charles H. (7)
Smith, Christopher A. (7)
Smith, DeWitt H. (11)
Smith, Elroy W. (16)
Smith, Frank W. (11)
Smith, Harold W. (7)
Smith, Henry G. (7)
Smith, Herman (21)
Smith, Ivan B. (12)
Smith, J. Meredith (7)
Smith, James D. (4)
Smith, John A. (12)
Smith, John V. (12)
Smith, Joseph A. (12)
Smith, Leon A. (16)
Smith, Leonard H. (7)
Smith, Marcia V. (5)
Smith, Marshall (12)
Smith, Meyer (9)
Smith, Nehemiah E. (2)
Smith, Percy L. (11)
Smith, Sydney F. (12)
Smith, Thayer A. (7)
Smith, Wilbur A. (4)
Smolev, Joseph M. (16)
Snape, William J. (4)
Snavely, Earl H. (7)
Snedecor, Spencer T. (2)
Snegireff, Leonid S. (11)
Snyder, Howard P. (20)
Snyder, James A. (5)
Snyder, W. Jay (9)
Sobel, I. Jerome (16)
Sobin, Julius (7)
Sochacki, Alexander (4)
Sokoloff, Oscar J. (12)
Solk, Arthur G. (7)
Sollami, William R. (11)
Solomon, Harold (7)
Solomon, Louis (9)
Solworth, Lee (2)
Somberg, Harold (7)
Somers, Fred L. (7)
Somers, Williard H. (2)
Sommer, George N. J. (11)
Sommer, George N. J., Jr. (11)
Sooy, L. Thomas (8)
Sordillo, Anthony (20)
Soschin, Samuel J. (7)
Sosnow, Louis M. (2)
Sottilaro, Joseph J. (9)
Spaldo, John L. (18)
Spallone, Joseph C. (7)
Spano, Frank (9)
Sparks, Paul R. (3)
Sparks, Spurgeon, Jr. (7)
Spath, William H. (9)
Speer, Charles A. (20)
Spence, Harold G. (7)
Spencer, Alvan (14)
Spencer, Ira T. (12)
Spencer, James H., Jr. (19)
Sperber, Thomas J. (2)
Sperling, Irving L. (7)
Sperling, Walter (7)
Spicola, Louis A. (2)
Spiegelglass, Abraham B. (2)
Spillane, Timothy H. (21)
Spinner, Samuel L. (7)
Spinnler, Henry R. (16)
Spirito, Michael W. (20)
Spivack, David (20)
Spivack, Seymour E. (20)
Spohn, Eugene L. (9)
Spradley, Jeems B. (11)
Sprague, Edward W. (7)
Spranz, William S. (2)
Spritzer, Theodore D. (12)
Spurgeon, Dorsett L. (19)
Stabile, John A. (11)
Staehle, Richard H. (7)
Stage, Earl DeW. (14)
Stahl, Alfred (7)
Stahl, Charles (7)
Staknevich, John H. (7)
Stamps, G. Ruffin (1)
Stark, Jacob (16)
Starr, Benjamin (9)
Starr, Eli (9)
Starr, George R., Jr. (7)
Statile, Pasquale A. (9)
Statman, Arthur J. (7)
Staub, E. Milton (20)
Stearns, Thornton (7)
Steel, William A. (5)
Steele, Stephen (20)
Stefansin, Frank (9)
Steffens, Charles T. (20)
Stein, Albert (9)
Stein, Emil (20)
Stein, Frederick (2)
Stein, George H. (20)
Stein, Harold M. (16)
Stein, Harriet N. (16)
Stein, Isadore (20)
Stein, Jacob M. (9)
Stein, Joseph M. (4)
Stein, Louis A. (11)
Stein, Martin H. (20)
Stein, William (12)
Steinberg, Werner (20)
Steiner, Edwin (7)
Steiner, Herbert (7)
Steitz, John A. (3)
Stellar, Frederick C. (13)
Stephenson, Daniel H. (4)
Stephenson, Gordon A. (20)
Stern, David A. (7)
Stern, Max E. (7)
Stern, Morton M. (7)
Steuart, David F. R. (14)
Stevens, Merton H. (7)
Stevenson, G. McKay (20)
Stevenson, George S. (13)
Stewart, Irving J. (8)
Stewart, Katherine E. (19)
Stewart, Robert G. (7)
Stewart, Sloan G. (1)
Stewart, Walter B. (1)
Stickles, Lloyd C. (7)
Stier, Howard W. (16)
Stiles, C. Campbell (7)
Stockfisch, Robert H. (9)
Stoddard, Gordon V. (7)
Stokes, Anthony T. (9)
Stokes, Donald E. (7)
Stokes, James S. (16)
Stokes, S. Emlen (3)
Stoll, George F. (7)
Stolow, Alan A. J. (18)
Stoltz, Raymond R. (16)
Stone, Frank P. (4)
Stone, Russell B. (21)
Stoner, William H. (7)
Storaci, Frank S. (11)
Storer, Alexander, Jr. (4)
Stouter, Francis L. (16)
Strack, Vincent J. (7)
Straub, Herbert H. (7)
Straus, Frederick W. (4)
Straus, Max (7)
Straus, Walter (11)
Strauss, Arthur (13)
Strauss, Clifton J. (20)
Strauss, Frederick (7)
Strauss, William T., Jr. (7)
Streen, Morris E. (7)
Strelinger, Alexander (20)
Strenski, John (3)
Strom, Abraham (20)
Strully, Leonard V. (16)

Stuart, J. Earle (20)
Stuart, William C. (9)
Sturchio, Edoardo (7)
Sturchio, Eugenio (7)
Stybel, Joseph (20)
Subin, Harry (1)
Sucoff, Moses C. (16)
Suesserman, Henry (7)
Suffness, Gustave (20)
Sufrin, Emanuel (4)
Sullivan, Charles J. (12)
Sullivan, Claude C., Jr. (4)
Sullivan, James M., III (11)
Sullivan, John A. (2)
Sullivan, William M., Jr. (16)
Summerill, Garnett (4)
Summers, Alfred D. (11)
Summey, Thomas J. (3)
Surgent, George W. (16)
Surran, Carl A. (1)
Sussman, Harold (9)
Suter, Harry F. (17)
Sutnick, Theodore B. (11)
Sutton, Joseph G. (7)
Svenson, Sven E. (7)
Swain, Richard D., Jr. (7)
Swern, Nathan (11)
Swiecicki, Martin E. (4)
Swiney, Juliana C. (9)
Swiney, Merrill A., III (9)
Sydoriak, Vladimir L. (6)
Symes, Earl R. (7)
Szerlip, Leopold (7)
Szittya, Sandor (21)
Szivos, Louis A. (7)
Szold, Norman F. (15)
Szuch, Nicholas (12)
Szymanski, John J. (16)

ASSOCIATE MEMBERS

Sadoff, Irvin E. (12)
Salasin, Robert G. (1)
Sandford, Francis R. (7)
Santangelo, Joseph A. (7)
Sarno, John (7)
Savage, Eric D. (7)
Scalera, John F. (12)
Schaefer, Kenneth F. (7)
Scheip, James R., II (2)
Schnur, Bernard (11)
Schultz, Leo P. (2)
Schwager, Alfred J. (11)
Schwartzfeld, Hyman (7)
Scillieri, Frank (16)
Seely, Richard H. (11)
Selikoff, Irving (16)
Shaffrey, Thomas A. (7)
Sheldon, Siegfried (7)
Siegel, Leo (7)
Siegel, Robert (7)
Siegel, Simeon (2)
Simon, Franklin (7)
Sims, Eugene R. (7)
Smith, Alan L. (7)
Sobol, Betty M. (7)
Sobol, Herman (7)
Spagnolo, Peter J. (13)
Spinosa, William J. (7)
Spitaleri, Liborio N. (2)
Sporer, Andrew (16)
Stanley, Thomas A. (7)
Statman, Bernhardt (7)
Steneck, Gustav G. (2)
Stevens, Donald J. (7)
Stollman, Bernard D. (12)
Strassburger, Paul J., Jr. (7)
Strazza, John A. (7)
Sweeley, William J. (7)
Szafir, Paul (16)
Szelewa, Edward S. (7)

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ACTIVE MEMBERS

Taber, Frederick S. (12)
Taber, Leslie R. (16)
Taff, Harry (7)
Taffet, William (7)
Taft, Herman L. (9)
Talmage, William G. (14)
Talty, John C. (9)
Tannert, Carl H. (9)
Tansey, W. Austin, Jr. (7)
Taranto, Michael (20)
Tarbell, Harold A. (7)
Targan, Nathan (1)
Tarta, Ciro S. (16)
Tataryan, Hovsep (9)
Tatem, Henry R., Jr. (4)
Tator, Arthur E. (20)
Taylor, Earl S. (11)
Taylor, John H. (11)
Taylor, Raymond A. (15)
Teeter, Charles E. (7)
Teichholz, Max H. (16)
Tell, M. Edward (16)
Teller, Daniel W., Jr. (14)
Temes, J. Howard (9)
Tenney, Albert S. (7)
Tenney, Luman H. (11)
Tennis, Edgar M. (2)
Tepper, Victor (7)
terKuile, Reinold W. (2)
Terreri, D. Joseph (14)
Terwedow, Henry (9)
Terwedow, Walter G. (9)
Teskey, Stanley (14)
Tether, Russell K. (2)
Thalheimer, Edward J. (6)
Thomas, Claude W. (17)
Thomas, George N. (6)
Thomas, Irene O. (16)
Thomas, John H. (7)
Thomas, Leon H. S. (16)
Thomas, Ralph B. (9)
Thomas, Thomas S., Jr. (14)
Thomison, Harry E. (7)
Thompson, Arthur F. (7)
Thompson, Edward C. (16)
Thompson, Kenneth W. (7)
Thompson, Minturn R. (20)
Thompson, Penrose H. (4)
Thompson, Victor (13)
Thompson, Walter A. (16)
Thompson-Bohne, Mildred H. (20)
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Thorne, Nathan (3)
Thorne, William P. (16)
Thornhill, Arthur C. (7)
Thornley, William F. (7)
Thron, Leopold E. (16)
Thum, Kurt W. (7)
Thurm, Arthur S. (11)
Tidaback, Austin J. (20)
Tidaback, John D. (20)
Tidwell, Harold F. (9)
Tillis, Herman H. (7)
Tilton, William R. (7)
Timberlake, Baxter H. (1)
Tisch, Leon (12)
Tobey, Franklin J. (7)
Tobey, John R. (7)
Tocci, Frank (7)
Toczek, Heinrich A. (7)
Todd, Francis H. (16)
Tolomeo, Martin E. (18)
Tolor, Stanley (20)
Tomaiuoli, Michele (9)
Tomec, Otto C. (11)
Tomec, Richard F. (7)
Tomkins, William (16)
Tomlins, Francis I. (2)
Tomlinson, Rolland D. (20)
Tompkins, Grenelle B. (10)
Torppey, John J. (7)
Towbin, Adolph (15)
Townsend, John B. (5)
Townsend, Leslie M. (20)
Toy, Calvert R. (12)
Tracy, George T. (3)
Traganza, Robert W. (4)
Trano, Giovanni (20)
Trautwein, Charles F. (7)
Travers, Frank A. (7)
Treiber, Benjamin A. (11)
Tretter, Hans L. (11)
Trewhella, Arthur P. (9)
Triarsi, Anthony J. (20)
Trippe, Morton F. (13)
Troedsson, Bror S. (7)
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Truax, Alfred J. (14)
Tsucalas, James C. (9)
Tucker, Albert B. (7)
Tucker, Sidney (12)
Tuly, Ralph (7)
Tunis, Benno B. (7)
Turi, Amedeo E. (7)
Turner, Charles F. (7)
Turner, Rodney C. (11)
Tushnet, Leonard (7)
Tutela, Arthur C. (7)

Tweddel, George K. (16)
Twitchell, Adelbert B. (7)
Tymeson, Walter R. (7)
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Tyndall, Hugh H. (9)
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Thompson, William P. (11)
Tilley, John A. (13)

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Udinsky, Hyman J. (16)
Uhr, Jacques S. (12)
Ulan, Jerome (12)
Ulan, Oscar (7)
Ulmer, Chester I. (8)
Ulmer, D. H. Bartine (3)
Ulvestad, Lawrence E. (7)
Underwood, J. Harris (8)
Upham, Helen F. (13)
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Urbaniak, Henry S. (11)
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Urevitz, Abraham (9)
Utkewicz, Edmond A. (9)
Uzzell, Edward F. (1)

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Vallario, Frank A. (7)
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Vanderbeck, James J. (16)
Vanderbeek, Andrew B. (16)
Vanderbeek, Frank B. (16)
Vanderbeek, Stuart W. (2)
Vander Clock, Cornelius (16)
Vandersluis, Harold H. (2)
Vander Veer, H. Garrett (7)
Van Dyke, Joseph S. (2)
Van Eerde, Albert (16)
Van Emburgh, George H. (7)
Van Gieson, Edward J. (7)
Van Mater, John S. (12)
Vann, Dorothea D. (2)
Vann, Felix H. (2)
Vannatta, George W. (7)
Vanneman, Joseph S. (11)
Van Ness, H. Roy (7)
Van Riper, William D. (2)
Van Schott, Gerard J., Jr. (16)
Van Wiemokly, Seymour S. (14)
Van Winkle, Charles I. (2)
Van Winkle, John S. (16)
Vargyas, Joseph C. (12)
Varney, William H. (21)
Varriano, John L. (9)
Vento, Sebastian J. (11)
Verbeck, George B. (7)
Verdon, Robert E. (2)
Verga, Armand (13)
Vermes, Leslie (19)
Vermeulen, Abram (16)
Vernaglia, Anthony P. (16)
Vespignani, Pasquale (9)
Villanova, Ralph N. (7)
Villapiano, Joseph G. (13)
Vincent, Nicholas F. (7)
Vinciguerra, Michael (20)
Vine, Blair (11)
Virgilio, Anthony A. (7)
Visceglia, Frank R. (9)
Visconti, Joseph A. (9)
Vita, Frank J. (2)
Vitale, Dominic V. (20)
Viteri, Luis E. (3)
Viti, Henry A. (9)
Vogel, H. Austin (20)
Vogel, Nathan F. (20)
Vol-Tretter, Marta (11)
von Deilen, Henry O. (14)
Von Hofe, Frederick H. (7)
Von Oehsen, William H. (13)
Voorhies, William S., Jr. (14)
Voorhis, Charles F. (3)
Vosburgh, Fred (16)
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Voss, John C. (3)
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Van Ness, Walter, Jr. (7)
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Wagner, Richard (20)
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Waldron, Robert E. (7)
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Walker, Harold G. (16)
Walker, H. Burton (6)
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Walker, Robert B. (12)
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Wallen, Benjamin B. (5)
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Walsh, Thomas J. (20)
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Walton, Ralph W. (7)
Wandall, Frederick G. (8)
Wangner, William F. (7)
Wantoch, Joseph (12)
Warburton, Jack C. (16)
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Weiner, Henry T. (12)
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Wilner, Irving (11)
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Wolf, Frank A. (21)
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Wolfe, William W. (7)
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Woodruff, Ralph G. (13)
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Wortman, Herbert M. (7)
Wren, James C. (2)
Wrensch, Alexander E. (7)
Wright, Herman W. (8)
Wright, Ralph S. (4)
Wroblewski, Benjamin M. (4)
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Wry, Orlin V. (2)
Wuerthele, Virginia E. (7)
Wuester, William O. (20)
Wujciak, Henry J. (7)
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Weiss, William I. (7)
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Williams, John R. (2)
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Winder, Miles S., Jr. (13)
Winn, James S. (12)
Winn, William M. (12)
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Y

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Yates, John S. (16)
Yeaton, William L., Jr. (9)
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Yelin, Gabriel (7)
Yellin, Charles H. (20)
Yingling, Paul L. (5)
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York, James L. (2)
York, Wilbur H. (11)
Yorke, Benjamin (16)
Yorke, Edward T. (20)
Young, Franklin C. (20)
Young, George J. (14)
Young, I. Henry (7)
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Young, Ralph A. (20)
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Zahn, Jack R. (8)
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Zapf, Reville D. (8)
Zappala, John (17)
Zbar, Joseph E. (9)
Zdanowicz, Stefan J. (21)
Zehnder, A. Charles (7)
Zeitlin, Herman H. (20)
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Zick, Clara U. (16)
Ziegler, Frederick (4)
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Zimmer, William (7)
Zimmerman, Coler (7)
Zimmerman, Robert F. (14)
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Zingali, John A. (7)
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Zitani, Alfred M. (9)
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Zuckerman, Louis (16)
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